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No. 08- ____

IN THE

Supreme Court of the United States

GOLDEN GATE RESTAURANT ASSOCIATION,
Petitioner,

v.

CITY AND COUNTY OF SAN FRANCISCO,
Respondent,

SAN FRANCISCO CENTRAL LABOR COUNCIL, *et al.*,
Intervenors / Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

San Francisco's Health Care Security Ordinance—a "pay-or-play" law—mandates either ongoing employer contributions at set minimum rates for employee health-benefits or equal payments to the City's Health Access Program, along with extensive recordkeeping and reporting and disclosure requirements. In a decision directly conflicting with Supreme Court ERISA preemption decisions, the Ninth Circuit rejected petitioner's ERISA-preemption challenge despite repeated *amicus* support by the Secretary of Labor. Identifying "an issue of exceptional national importance," an eight Judge dissenting opinion from denial of rehearing *en banc*, including Chief Judge Alex Kozinski, observed that the decision "creates a circuit split with the Fourth Circuit . . . , renders meaningless the [ERISA preemption] tests the Supreme Court set out in *Shaw v. Delta Airlines* . . . , and disregards the "need for nationally uniform plan administration." It also warned that the decision "will undoubtedly serve as a roadmap in jurisdictions across the country on how to design and enact a labyrinth of laws requiring employer compliance on health care expenditures, thereby creating the very kind of health care balkanization ERISA was intended to avoid."

The Question Presented is:

Whether ERISA section 514(a), 29 U.S.C. § 1144(a), preempts local laws mandating ongoing employer contributions for employee health-benefits, or alternative payments to a local government, and extensive recordkeeping and reporting and disclosure requirements, a question on which the courts of appeals are in conflict.

RULE 14.1(b) LISTING AND RULE 29.6 NOTATION

Petitioner is the Golden Gate Restaurant Association. Respondent is the City and County of San Francisco. Intervenors/Respondents are the San Francisco Central Labor Council, Service Employees International Union, Local 1021, SEIU United HealthCare Workers-West and UNITE HERE! Local 2.

Petitioner is a private non-profit corporation. It has no parent company and there is no publicly owned company that owns any stock of the petitioner.

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Employee Benefits Security Administration, U.S. Department of Labor, Field Assistance Bulletin 2004-1 (Apr. 7, 2004) 10
Julia Contreras and Orly Lobel, "Wal-Martization and the Fair Share Health Care Acts," 19 St. Thomas L. Rev. 105, 136 (2006) 20
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CITY AND COUNTY OF SAN FRANCISCO,
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Intervenors / Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

PETITION FOR WRIT OF CERTIORARI

Petitioner, Golden Gate Restaurant Association ("Golden Gate"), respectfully submits that a writ of certiorari should issue to review the judgment and opinion of the United States Court of Appeals for the Ninth Circuit in this case, an opinion which conflicts with *Retail Industry Leaders Ass'n v. Fielder*, 473 F.3d 180 (4th Cir. 2007).

OPINIONS BELOW

The opinion of the Court of Appeals is reported at 546 F.3d 639 (9th Cir. 2008), and is reprinted in the Appendix ("App.") at 1a to 40a. The concurring and

dissenting opinions to the denial of rehearing *en banc* (App. 41a to 61a) are reported at 558 F.3d 1000 (9th Cir. 2009). The Secretary of Labor's *amicus* brief in support of rehearing appears at App. 62a to 82a. The District Court's opinion granting summary judgment to Golden Gate (App. at 83a to 103a) is reported at 535 F.Supp.2d 968 (N.D. Cal. 2007). The relevant provisions of San Francisco's Health Care Security Ordinance and regulations appear at App. 106a to 158(a).

JURISDICTION

The Court of Appeals' order denying rehearing *en banc* was entered on March 9, 2009. This Court has jurisdiction pursuant to 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

The relevant provisions of the federal statute involved in this case are reproduced at App. 104a to 106a.

STATEMENT OF THE CASE

This case raises a critically important, recurring question relating to the preemptive scope of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, *et seq*. The controversy, which has already divided the circuits, centers on recent attempts by state and local governments to mandate employer contributions for employee health-benefits through the device of "pay-or-play" laws, sometimes known as "fair-share" laws.

Employee benefit plans are "affected with a national public interest"[1] as reflected in the current healthcare-reform efforts at the national level.

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[1] ERISA section 514(a), 29 U.S.C. § 1144(a).

ERISA governs employee benefit plans and establishes a scheme which encourages, but does not mandate, that employers provide benefits for their employees.[2] Although ERISA sets "various uniform standards, including rules concerning reporting, disclosure, and fiduciary responsibility" for plans, "private parties, not the Government, control the level of benefits."[3] Congress designed this flexibility to encourage employers to adopt uniform employee benefit plans with streamlined administration and initially generous benefits, knowing they may amend or terminate the plans at any time.[4]

ERISA's preemption provision is at the very heart of the statute. This provision protects ERISA's central goals including the autonomy of plan sponsors to decide whether to provide plans at all and, if so, to establish plans with cost-effective, nationally-uniform benefits, benefit levels and administration.[5] Ensuring these objectives, ERISA preempts state and local laws that "prohibit" what is "permitted" by federal law,[6] "mandate[] employee benefit structures,"[7] impose "different regulations on plans and *plan sponsors* from jurisdiction to jurisdiction,"[8] or permit par-

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[2] *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 91 (1983).

[3] *Curtiss-Wright Corp. v. Schoonenjongen*, 514 U.S. 73, 78 (1995).

[4] *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 511 (1981).

[5] *Shaw*, 463 U.S. at 105 n. 25; *N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 658 (1995).

[6] *Travelers*, 514 U.S. at 658.

[7] *Id.*

[8] *Egelhoff v. Egelhoff*, 532 U.S. 141, 146-147 (2001)(emphasis added).

ticipants to obtain "benefits in excess of what plan administrators intended to provide, and in excess of what the plan provides to employees in other states."[9]

A. Development of "Pay-Or-Play" Laws and the Challenge to These Laws

Although "pay-or-play" laws are recent developments, their DNA traces back to the employer mandated-contributions and noncompliance-penalty provisions of the Hawaii Prepaid Health Care Act held ERISA-preempted over a quarter century ago. *Standard Oil Co. of Calif. v. Agsalud*, 633 F.2d 760 (9th Cir. 1980), *summarily aff'd*, 454 U.S. 801 (1981).[10]

Congress wanted to leave employee welfare benefit plans completely voluntary.[11] As a result, plan sponsors have the right under ERISA "for any reason at any time, to adopt, modify, or terminate welfare plans."[12] Congress knew that if it placed a heavy regulatory-hand on welfare plans, as it did with pension plans in terms of regulating minimum participation, funding, vesting and plan termination, employers would be likely to abandon health-plans entirely, the exact opposite of Congress's goal.

One of Congress's purposes in enacting ERISA's broad preemption provision was to foreclose the employer contribution mandates in the health-reform

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[9] *Id.*

[10] Shortly thereafter, Congress amended ERISA to provide a narrow exemption for the Hawaii Act, making clear that the amendment did not establish a precedent for amendments for any other state laws Pub.L.No. 97-473, § 301(b), 96 Stat. 2605, 2612 (1983).

[11] *Curtiss-Wright.*, 514 U.S. at 78.

[12] *Id.*

statutes that were precursors to the "pay-or-play" laws. These statutes included the Hawaii Act and a similar measure that was being considered in California.[13] The sheer number of the nation's political subdivisions—50 states and over 30,000 cities, counties and towns—ruled out the feasibility of local experiments with mandates applicable to sponsors of multistate plans. The spread of local mandates would collapse the nation's employee benefit plan system.

Congress also recognized that a state-by-state approach to employee benefits—rather than the carefully-balanced national approach adopted by ERISA—would unravel the great legislative compromise leading to ERISA's enactment.[14] Business and labor groups agreed to the continued voluntary nature of the employee benefit plan system, one to be governed by robust federal regulatory standards nationwide. This was only in exchange, however, for a broader-than-originally-proposed, "deliberately expansive"[15] preemption provision. ERISA sweeps aside not just state laws regulating areas specifically-covered by ERISA, but all state regulation in the employee benefit field outside of laws regulating insurance, banking or securities.[16]

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[13] *See* Michael S. Gordon, "Health Care Reform: Managed Competition and Beyond," Employee Benefits Research Institute, Issue Brief No. 135, 28-30 (March 1993).

[14] *See* Michael S. Gordon, "Introduction: The Social Policy Origins of ERISA," *Employee Benefits Law* (S.J. Sacher and J.I. Singer, eds., ABA, 2d ed., 2000), at c-cii.

[15] *Pilot Life Ins. Co. v. Dedeaux*, 491 U.S. 41, 46 (1987).

[16] ERISA sections 514(a), (b)(2)(A), 29 U.S.C. §§ 1104(a), (b)(2)(A).

The Ninth Circuit's decision demonstrates that Congress's concerns in 1974 are valid today. In addition to the "pay-or-play" law in San Francisco's Health Care Security Ordinance, Massachusetts has a "fair-share" law requiring certain employers to provide group health-insurance and pay premiums in set-amounts or face a penalty.[17] At the time this litigation was filed, at least 15 other states, including New York, New Jersey, Connecticut and Illinois, had comprehensive healthcare-reform bills or proposals under review.[18]

One of the many problematic aspects of the "pay-or-play" laws and proposals is that they impose not only differing employer minimum-contribution mandates based on different formulas, but also differing alternative government assessments and differing requirements for recordkeeping and reporting and disclosure. The laws also cause the siphoning of benefits from jurisdictions which do not have such laws to those which do. The laws apply both to local employers and employers located anywhere with a minimum threshold of local employees.

While well-intentioned, a "pay-or-play" approach focuses exclusively on local concerns and interests at the unacceptable cost of upending two of ERISA's most important principles. The first principle is that

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[17] MASS. REGS. CODE tit. 114, chap. 5, §§ 16.03(3)(c-d) (2009).

[18] *See* Peter Marathas, Jr., Robert W. Rachal and Yolanda Montgomery, "United States: Pay-or-Play State Health Insurance Laws and ERISA Preemption," *HR Advisor*, Vol. 14, No. 3, May/June 2008, 1-2. New Jersey's proposed "health-care-expenditures" bill is in A. 1966, 213th Leg., 2008-2009 Sess. Connecticut's proposed bill for employer contributions to a state-operated-healthcare-fund is in H.B. 6600, 2009 Gen. Assem. Reg. Sess., § 15(e).

employee benefit plans, including health-plans, are to be completely voluntary,[19] not subject to any mandates including employer contributions.[20] The second principle is that if a sponsor sets up a plan, the "'tailoring of plans and *employer conduct* to the peculiarities of the law of each jurisdiction' is exactly the burden that ERISA seeks to eliminate." *Egelhoff v. Egelhoff*, 532 U.S. 141, 151 (2001)(emphasis added). Moreover, there are many types of state-and-local fees and assessments that can fund healthcare-reform without doing what ERISA proscribes—"mandat[ing] employee benefit structures or their administration"[21] and "interfer[ing] with nationally uniform plan administration."[22]

Concerned about the extraordinary costs of compliance with diverse and conflicting "pay-or-play" laws and the resulting employee layoffs, business-relocations and closures, employer associations have challenged a number of these laws as ERISA-preempted.

In *Retail Indus. Leaders Ass'n v. Fielder*, 473 F.3d 180 (4th Cir. 2007), the Fourth Circuit sustained an employer association's ERISA preemption challenge to Maryland's "fair-share" law. The Secretary of Labor's *amicus* briefing supported this challenge, arguing that the law negated the "fundamental goal of ERISA preemption – the establishment of a uniform regulatory regime over employee benefit plans."[23]

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[19] *Curtiss-Wright, supra.*

[20] *Agsalud, supra.*

[21] *Travelers*, 514 U.S. at 658.

[22] *Egelhoff*, 532 U.S. at 148.

[23] Brief as *Amicus Curiae* at 10, available at http://www.dol.gov.sol/media/briefs/RILA(A)-11-07-2006.htm

The statute required large employers either to pay at least a specified percentage of total payroll for employees' health-insurance costs or to pay the shortfall as a penalty to the state for general-entitlement purposes. It also required employers to report annually the number of employees and the percentage-of-payroll spent on health-insurance.

Relying on *Fielder*, *supra*, a District Court in the Eastern District of New York held that ERISA preempts a Suffolk County "fair-share" law which required certain employers to provide at least $3.00 per hour in health-benefits to their employees, or to pay a civil penalty for the shortfall. *Retail Indus. Leaders Ass'n v. Suffolk County*, 497 F.Supp.2d 403 (E.D.N.Y. 2007).

The Ninth Circuit's decision in this case stands in direct conflict with *Fielder*, *supra*. The decision undoubtedly will lead to the development of more "pay-or-play" laws, as pointed out by the San Francisco City Attorney's description of the decision as "a road map for state and local governments" seeking to enact "fair share" laws.[24]

B. San Francisco's Health Care Security Ordinance

San Francisco's "pay-or-play" law is part of its Health Care Security Ordinance, S.F. Cal. Admin. Code, Ch. 14, which became effective in 2008.

The San Francisco Ordinance created the Health Access Program, known as "HAP." The HAP pools risks among program-participants and, through its

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[24] Jason Dearen, "Federal Court Upholds San Francisco Healthcare Program," *Los Angeles Times*, Sept. 30, 2008 (quoting City Attorney Dennis Herrera).

third-party administrator, maintains a network of approved San Francisco hospitals and clinics in much the same way as a private-HMO or PPO.

Local taxes, grants and other San Francisco revenues fund the overwhelming majority of the HAP's budget.[25] The HAP is open to uninsured City residents regardless of employment status. A resident may receive discounted medical services through the HAP by becoming a "participant" and paying quarterly income-based premiums, known as "participation fees."

If the Ordinance had stopped here, ERISA's preemption rules would not come into play. San Francisco went further, however, also requiring employers to provide ongoing funding for their employees' healthcare and follow an ongoing administrative scheme with extensive recordkeeping, reporting-and-disclosure and inspection dictates.

The Ordinance's expenditure rules cover "health care services" which are defined as including "medical care, services, or goods." That definition is virtually identical to ERISA section 3(1)'s definition of the benefits provided by an employee welfare benefit plan as including "medical, surgical, or hospital care or benefits." 29 U.S.C. § 1002(1). The Ordinance's expenditure rules apply to employers with twenty-or-more employees,[26] wherever located, so long as at

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[25] *See January* 2009 Status Report on the Implementation of the San Francisco Health Care Security Ordinance, 13.

[26] Employees are covered if they are employed for at least 90 days and perform at least 8 hours of work per week in San Francisco.

least one employee performs occasional work within the City.[27]

Employers have only two viable options to satisfy the mandate, both of which are ERISA-covered. The first is to establish their own health-plans, whether through group insurance or otherwise. Alternatively, under a "City-payment-option," employers may enroll their employees with the City and make quarterly-payments to the HAP. If eligible employees sign up for HAP, the employer contributions are allocated to them and reduce their participation fees by 75%.[28]

The Ordinance and City regulations impose a maze of ongoing administrative obligations, which are characteristic of "pay-or-play" laws. Among other administrative burdens, employers must differentiate hours worked by employees inside and outside of the jurisdiction; differentiate hours paid to "managerial," "supervisory" or "confidential" employees after making a discretionary determination on exemptions; track and report employment data for all companies in the same "controlled group," wherever located; differentiate and report health-expenditure amounts, including making annual-reports to the jurisdiction and quarterly-reports to individuals; and maintain sufficient documentation to prove that any reduction-

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[27] The 2009 rate is $1.23-per-hour for employers with 20-99 employees, and $1.86-per-hour for employers with 100-or-more employees.

[28] Eligible employees are City-residents who meet certain family-income-levels, have been uninsured for at least 90-days, are not eligible for public assistance and are between ages 18-and-64. For ineligible employees, the employer contributions fund health-savings-accounts which are ERISA-covered. Employee Benefits Security Administration, U.S. Department of Labor, Field Assistance Bulletin 2004-1 (Apr. 7, 2004).

in-force was not implemented to avoid the law's obligations. Non-compliance results in substantial daily administrative and civil penalties and attorney's fees and costs of enforcement.

If the Ninth Circuit's decision is allowed to stand, an employer with just 10 locations in different parts of the country could also easily face 10 different sets of such complex laws. An employer with 100 locations could face far more.

C. The District Court Proceeding

On November 8, 2006, Golden Gate filed a lawsuit in the District Court for the Northern District of California contending that ERISA bars the Ordinance's health-contributions mandate both through express and conflicts preemption. Golden Gate made four basic arguments.

First, as in *Fielder*, *supra*, ERISA preempts the contributions-mandate because it is, however artfully styled, an ERISA-preempted benefits-mandate. It requires employers to fund employee benefits for healthcare, and only healthcare, at set-minimum levels. It has an impermissible "connection with" ERISA plans because it interferes, in the same way as a benefits-mandate, with an employer's fundamental authority to decide whether to establish plans and to achieve cost-savings by setting nationally-uniform benefits, benefit levels and administrative practices.

Second, the Ordinance has an impermissible "connection with" ERISA plans *regardless* of the option chosen, because all of the options involve ERISA plans. Under the "City-payment-option," the employer establishes an ERISA plan for its employees in the same manner as it establishes an ERISA plan by paying group health-insurance premiums.

Third, even if the "City-payment-option" did not involve an ERISA plan, ERISA preempts the Ordinance because, as in *Fielder*, the law requires a "reference" to the employer's existing ERISA plan to see whether the required contribution levels are met.

Fourth, as in *Fielder*, ERISA preempts the Ordinance under conflicts preemption because it frustrates ERISA's objectives of an economical, voluntary plan system allowing nationally-uniform benefits, benefit levels and administrative practices.

On December 21, 2007, the District Court granted summary judgment to Golden Gate. The court held that the Ordinance has a prohibited "connection with" ERISA plans because its local requirements interfere with nationally-uniform plan administration; by mandating minimum-health expenditures, it regulates the types of benefits provided by ERISA plans; it imposes recordkeeping, inspection and other administrative burdens related to plan administration; and it makes unlawful reference to ERISA plans by requiring employers to modify plan administration or to structure additional payments by reference to amounts paid under existing plans. *Golden Gate Restaurant Association v. City and County of San Francisco*, 535 F.Supp.2d 968 (N.D.Cal. 2007). App. at 83a to 103a.

D. Ninth Circuit Stay, Opinion, and Order on Petition for Rehearing

On December 27, 2007, the City and several intervenors filed an emergency motion for stay of judgment with the Ninth Circuit's December 2007 motions panel. The motions panel, consisting of Judges Goodwin, W. Fletcher and Reinhart, granted the

stay.[29] Golden Gate petitioned to vacate the stay but, after ordering further briefing, Justice Kennedy declined to vacate the stay order.

The motions panel retained the case on the merits. The Secretary of Labor along with eight national entities filed *amicus* briefs supporting ERISA preemption.

On September 30, 2008, the Ninth Circuit reversed the District Court. The court held that a presumption against preemption applies because the Ordinance operates in an area of traditional state regulation; the Ordinance does not require employers to establish or to modify ERISA plans; the "City-payment-option" does not create an ERISA plan, because its administrative obligations do not involve an "ongoing administrative scheme" regulated by ERISA; and preemption is triggered by mandated-benefit laws, not by laws mandating contributions to pay for benefits. The court also declared that its holding does not conflict with *Fielder*, *supra*. *Golden Gate Restaurant Association v. City and County of San Francisco*, 546 F.3d 639 (9th Cir. 2008) ("*Golden Gate II*"). App. at 15a to 40a.

Golden Gate petitioned for rehearing *en banc*, again joined by *amici* including the Secretary of Labor who stated that the case involves a "recurring issue of exceptional importance." App. at 72a. Among other points, the Secretary argued that all options under the Ordinance involve ERISA plans and that *Golden Gate II* failed to apply properly the Supreme Court's ERISA preemption tests and reached a result inconsistent with *Fielder*, *supra*. App. at 72a to 81a.

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[29] *Golden Gate Restaurant Association v. City and County of San Francisco*, 512 F.3d 1112, 1119 (9th Cir. 2008).

On March 9, 2009, the Ninth Circuit denied rehearing. *Golden Gate Restaurant Association v. City and County of San Francisco*, 558 F.3d 1000 (9th Cir. 2009), App. at 41a to 61a. The order included a strong 11-page dissent joined by eight Judges, including Chief Judge Alex Kozinski.

The dissent described the case as involving "an issue of exceptional national importance." App. at 58a. "A currently non-complying employer in San Francisco," the dissent explained, "has the same choice as a non-complying employer in Maryland: Make a payment to the government or change its current ERISA plan." App. at 54a. The dissent added: "[p]er *Egelhoff*, a law like the San Francisco ordinance is ERISA-preempted because it frames employers' choices in this fashion." "Further," it wrote, "allowing San Francisco to pose such a choice would strike at the heart of ERISA because plan administrators would have to account for potential opt-out provisions in all 50 states." App. at 56a.

The dissent faulted the panel decision for creating a circuit split, rendering meaningless this Court's ERISA preemption tests in *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983), and conflicting with other Supreme Court decisions. App. at 49a. It warned that the decision "will undoubtedly serve as a roadmap in jurisdictions across the country on how to design and enact a labyrinth of laws requiring employer compliance on health care expenditures, thereby creating the very kind of health care balkanization ERISA was intended to avoid." App. at 60a.

On March 30, 2009, Golden Gate's Application to Justice Kennedy to stay the mandate of the Ninth

Circuit pending petition for writ of certiorari was denied, after a request for further briefing.

REASONS FOR GRANTING THE PETITION

I. THE NINTH CIRCUIT HAS DECIDED AN IMPORTANT AND RECURRING ERISA PREEMPTION ISSUE IN DIRECT CONFLICT WITH THE FOURTH CIRCUIT.

Once again the Ninth Circuit has brought itself sharply into conflict with another circuit on an important, recurrent federal issue which requires uniformity nationwide. The decision creates a direct conflict among ERISA preemption holdings in the circuits which only this Court can resolve.

A. The Circuits are Clearly Divided on Whether ERISA Preempts "Pay-Or-Play" Laws

In *Fielder*, *supra*, the Fourth Circuit struck down Maryland's "fair-share" law, while the Ninth Circuit's *Golden Gate II* decision upheld San Francisco's "pay-or-play" law.

The circuit split is at ERISA's epicenter, the dividing line between federal and state-and-local powers. The "pay-or-play" and "fair-share" laws prohibit what ERISA permits.

ERISA preempts state and local laws if they conflict with "an area of core ERISA concerns" or its "principal goals."[30] ERISA's paramount concerns and goals include giving plan sponsors the autonomy to decide whether to offer employee benefits[31] and to

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[30] *Egelhoff*, 532 U.S. at 146-147.

[31] *Curtiss-Wright*, *supra*.

design and administer plans in a cost-effective, uniform national regulatory environment.[32] ERISA's purpose also includes ensuring that employers will not be put to "the choice of operating separate ongoing benefit plans or a single plan subject to different regulatory requirements." *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 16-17 (1987). Further, ERISA's purpose includes ensuring that plan sponsors and plans will not be required to "calculate benefit levels" differently from jurisdiction to jurisdiction.[33]

Maryland's "fair-share" law required employers of a certain size to spend at least 8% of their total payrolls on employees' health-insurance or to pay the shortfall to the state as a penalty. The Fourth Circuit framed its ERISA preemption holding on two bases.

The Fourth Circuit concluded that ERISA preempts the "fair-share" law as having an impermissible "connection with" ERISA plans, even if there were some "meaningful avenue" by which employers would incur non-ERISA health-spending. Compliance would have direct effects on the employers' ERISA plans. If employers attempted to use non-ERISA spending options, employers would need to coordinate those spending efforts with existing ERISA plans. The categories of ERISA and non-ERISA health-spending would not be isolated, unrelated costs for the employer. Decisions regarding one would impact the other. *Fielder*, 473 F.3d at 196-197.

Supporting this basis, the Fourth Circuit explained that Maryland law, coupled with a proliferation of similar laws, would constantly force employers to

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[32] *Shaw*, 463 U.S. at 105 n. 25; *Travelers*, 514 U.S. at 657-658; *Egelhoff*, *supra*.

[33] *Travelers*, 514 U.S. at 657-658.

monitor state-law developments and "manipulate heath care spending to comply with them," thereby conflicting with *Egelhoff*, *supra*. *Fielder*, 473 F.3d at 197. *Egelhoff held* that ERISA preempted a state law that operates to revoke the designation of a divorced spouse as a life insurance beneficiary, even though the plan could opt out by a simple plan amendment saying that the state law did not apply. The state law had an impermissible "connection with" plan administration by requiring plan administrators "to maintain a familiarity with the laws of all 50 States so that they can update their plans as necessary." 532 U.S. at 151. Citing *Egelhoff*, the Fourth Circuit held that a "state law that directly regulates the structuring or administration of an ERISA plan is not saved by inclusion of a means for opting out of its requirements." *Fielder*, 473 F.3d at 192.

The Fourth Circuit also concluded that ERISA preempts the law because it has an impermissible "connection with" ERISA plans by offering employers no reasonable choice but to increase contributions to their ERISA healthcare plans. The state would earmark employer shortfall payments for general-entitlement programs, thus conferring no benefit on the employees. Reasonable employers would not spend their money in that fashion. *Fielder*, 473 F.3d at 196.

In contrast, the Ninth Circuit held that ERISA preemption extends only to benefits-mandates, not to contributions-mandates, and the latter do not interfere with ERISA's goals including uniform plan administration within a single jurisdiction. App. at 41-43a, 37-48a. The court, however, refused to follow an essential step in this Court's preemption analysis: a consideration of the law's impact on uniform plan

administration for multistate plans and the potential for increased burdens if other jurisdictions enacted similar laws. *Egelhoff*, 532 U.S. at 151.

The Ninth Circuit attempted to distinguish *Fielder* on the ground that the Maryland statute offered the employer no reasonable choice but to increase its ERISA contributions. The Ordinance avoids preemption, the court concluded, because the "City-payment-option" results in a benefit for employees; hence, a rational employer might choose that option. App. at 45-46a. The court neither addressed nor attempted to distinguish the Fourth Circuit's holding that even if there were some meaningful choice for an employer, ERISA preempts the law because it requires employers to coordinate their ERISA spending with non-ERISA spending and constantly to monitor other laws.

The Ninth Circuit's decision is in clear conflict with the Fourth Circuit's decision. The Ninth Circuit's attempted distinction of the cases does not withstand scrutiny.

ERISA preemption does not rise or fall based on the relative attractiveness of options to creating or amending an ERISA plan. ERISA preempts a law if it conflicts with the Act's purposes by putting the employer to a choice of either restructuring its plan or plan administration, or opting out while keeping its eyes on other spending-mandates. *Egelhoff*, 532 U.S. at 151.

ERISA also preempts a law which forces employers to make choices—even rational ones—that would result in "different obligations in different states," since this by itself would defeat ERISA's stated goal of uniformity in plan administration. *Egelhoff*, 532 U.S. at

148. Moreover, even if an employer has what appears to be a "rational" opt-out choice of one government-administered health program, the choice is far from "rational" when the employer may have to confront "rational" choices in different states, cities and counties. As noted by the Secretary of Labor's *amicus* brief, "[e]ven if the administrative burden imposed by a single law may be tolerable, the cumulative burden could be staggering." App. at 91a.

Eight dissenting Ninth Circuit judges found that the panel decision's distinction based upon the reasonableness of the "City-payment-option" "conflicts" with *Fielder*. App. at 53a. The dissent also pointed out that the decision conflicts with ERISA preemption standards set forth in Supreme Court decisions including *Shaw*, *supra*, and *Egelhoff*, *supra*. App. at 61a, 57a. The dissent concluded that "[t]he holdings of *Fielder* and *Golden Gate* stand in clear opposition, and create a split on the issue of whether ERISA preempts 'fair-share' or 'pay-or-play' ordinances." App. at 54a-55a.

Swift intervention by this Court is essential. The Ninth Circuit's decision causes a circuit split destroying national uniformity in not only the voluntary nature of health-plans, but also in plan design, benefit levels and administration, the very factors which allow cost-effective plans. This split is certain to widen in the future as additional states, cities and counties, seeking to cut government spending in harsh economic times, enact "pay-or-play" laws based on new models including the San Francisco Ordinance. ERISA's objectives include the avoidance of "the possibility of endless litigation over the validity of

State action that might impinge on Federal regulation."[34]

Professor Edward A. Zelinsky has closely followed the circuit conflict on "pay-or-play" laws. Questioning the Ninth Circuit's unique benefits-versus-contributions distinction, he wrote: "Under [ERISA] Section 514(a), state law is preempted when it 'relate[s]' to employee benefit plans, not when it 'relate[s] to plan's outputs' ... If [the court's] approach does not trivialize the matter of ERISA preemption, it comes close." "At some point, it will be necessary for the Supreme Court to resolve the conflict represented by Fielder and Golden Gate II."[35]

B. The Issue Presented by the Conflict is Recurring and of Great National Importance

The conflict among the circuits on ERISA preemption of "pay-or-play" laws is both recurrent and of great national importance.

As of 2006, "pay-or-play" laws had already been proposed or were under consideration by at least thirty states as well as local jurisdictions across-the-country. Julia Contreras and Orly Lobel, "Wal-Martization and the Fair Share Health Care Acts," 19 St. Thomas L. Rev. 105, 136 (2006). Many of these proposals faced immediate opposition based on their being obviously-preempted by ERISA. The Ninth Cir-

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[34] Sen. Jacob K. Javits, 120 Cong. Rec. 29942 (1974).

[35] "Golden Gate Restaurant Association: Employer Mandates and ERISA Preemption in the Ninth Circuit," Cardozo Legal Studies Research Paper No. 19, pp. 22, 31; State Tax Notes, Vol. 47, 2008; available at SSRN: http://ssrn.com/abstract=1090122:

cuit's decision has clouded this formerly-clear issue, making future proposals far more likely to succeed.

The circuit conflict created by the Ninth Circuit cuts to the core of ERISA. At stake are two of ERISA's fundamental principles, both of national significance.

First, the circuit split over "pay-or-play" laws disrupts the national interest in encouraging the voluntary formation of employee benefit plans protected and governed by a single body of federal law.[36] Congress' goal was to "ensure that plans and *plan sponsors* would be subject to a uniform body of benefits law."[37] Employers' flexibility to adopt, modify, or terminate welfare benefit plans at any time[38] "is not an accident;" it was intended to encourage employers to set higher benefit levels at the outset (since they may be reduced if economic conditions sour) by streamlining administration and decreasing plan costs.[39] Congress carefully balanced this autonomy with employee-protection provisions that expressly prohibit interference with existing benefits, and require employers to follow a plan's written procedures prior to amendment.[40] These statutory protections ensure "that employers do not 'circumvent the provision of promised benefits.'"[41]

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[36] ERISA section 2(a), 29 U.S.C. § 1001(a).

[37] *Travelers*, 514 U.S. at 645 (emphasis added).

[38] *Curtiss-Wright Corp*, 514 U.S. at 78.

[39] *Inter-Modal Rail Employees Ass'n v. Atchison, Topeka & Santa Fe Ry.*, 520 U.S. at 510, 515 (1997).

[40] *Id.* at 515-516; ERISA sections 510 and 402(b)(3), 29 U.S.C. §§ 1140 and 1102(b)(3).

[41] *Inter-Modal*, 520 U.S. at 515 (citation omitted).

Second, the circuit conflict disrupts the national goal of "*minimiz[ing]* the need for interstate employers to administer their plans differently in each State." *Shaw*, 463 U.S. at 105 (emphasis added). Congress designed ERISA so that interstate employers could operate plans in a uniform, cost-efficient fashion, and be able "'to predict the legality of proposed actions without the necessity of reference to varying state laws.'"[42] The "basic thrust" of ERISA preemption is to "avoid a multiplicity of regulation in order to permit the nationally uniform administration" of employee benefits. *N.Y. State Conf of Blue Cross & Blue Shield Plans v. Travelers Ins. Co. ("Travelers")*, 514 U.S. 645, 657-658 (1995). As this Court observed in *Egelhoff*, 532 U.S. at 149-150, "[r]equiring administrators to master the relevant laws of 50 States and to contend with litigation would undermine the congressional goal of 'minimiz[ing] the administrative and financial burden[s]' on plan administrators—burdens ultimately borne by the beneficiaries."

The circuit conflict raised by *Golden Gate II* will cause widespread confusion and spur further litigation. It also politicizes the critical issue of uniformity in plan design, benefits and administration, allowing individual judges to impose their own social perspectives in an area where Congress has insisted upon allowing national uniformity. The decision reopens the door for the very multiplicity of federal, state and local regulation—coupled with multi-tiered, excessive administration costs—that brought about ERISA's enactment. Unless resolved, the conflict also will impede the prospect of successful national healthcare-reform.

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[42] *Pilot Life*, 481 U.S. at 56 (citation omitted).

This circuit conflict on a significant and recurring ERISA preemption issue of national consequence is alone sufficient ground for this Court's review.

II. THE NINTH CIRCUIT'S DECISION DIRECTLY CONFLICTS WITH SUPREME COURT DECISIONS HOLDING THAT ERISA PREEMPTS STATE LAWS MANDATING EMPLOYER CONTRIBUTIONS OR PLAN BENEFITS.

Still another reason supports the granting of a writ of certiorari. By creating a novel-but-unwarranted distinction between "mandated-contributions" and "mandated-benefits," the decision does violence to the Act's text and architecture, and directly conflicts with this Court's ERISA preemption decisions.

A. The Decision Renders Meaningless this Court's ERISA Preemption Standards in *Shaw v. Delta Air Lines* and Directly Conflicts With Other Supreme Court Preemption Decisions

The Ninth Circuit's decision effectively strips this Court's ERISA preemption standards in *Shaw*, *supra*, of any meaning. The decision also directly contradicts later decisions of this Court holding that ERISA preempts state laws mandating employer contributions or plan benefits.

ERISA's preemption clause—called the "crowning achievement of [the] legislation," 120 Cong. Rec. 29197 (Aug. 20, 1974), remarks of Rep. Dent—most clearly reflected Congress' effort to eliminate the threat of inconsistent or local regulation of employee benefit plans and establish in its stead a comprehensive and pervasive federal scheme. *Shaw*, 463 U.S. at 99.

ERISA's preemption clause states that the Act supersedes any and all state laws that "relate to" any employee benefit plan, with a state defined as including its political subdivisions. ERISA sections 514(a), (c)(2), 29 U.S.C. §§ 1144(a), (c)(2).

In *Shaw*, 463 U.S. at 96, this Court held that ERISA preempts a New York law that mandated pregnancy benefits because dictating such substantive terms would "relate to" an employee benefit plan within the meaning of 29 U.S.C. § 1144(a). The words "relate to" mean have "a connection with" or "reference to" ERISA plans. *Id.* at 97.

In *Travelers*, this Court explained that "[t]o determine whether a state law has the forbidden connection, we look both to 'the *objectives of the ERISA statute* as a guide to the scope of the state law that Congress understood would survive,' as well as to the nature and effect of the state law on ERISA plans." 514 U.S. at 656 (emphasis added) (citation omitted). Accordingly, ERISA preempts laws that touch on central areas of ERISA by "prohibit[ing]" what is "permitted" by federal law, "mandating employee benefit structures or their administration," or by "preclud[ing] uniform administrative practice." *Id.* at 656-657. In assessing the burden a law places on uniform administrative practices, this Court takes a far-ranging look consistent with ERISA's purposes. Under examination are the impact of the particular law on plan sponsors, plans and administrators, as well as the potential for increased burdens if similar laws were enacted by other states. *Egelhoff*, 532 U.S. at 151.

In formulating preemption standards, this Court has explained that ERISA's goal was to encourage employers to establish plans voluntarily and eco-

nomically through a single, federal regulatory system that allows uniform administrative practices across-the-nation. *Fort Halifax*, 482 U.S. at 12. In striking a balance between competing federal and state interests, ERISA makes plan regulation "'exclusively a federal concern.'" *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 45-46 (1987)(citation omitted).

This Court has held that ERISA preempts state or local laws mandating employer contributions for group health-insurance, with a noncompliance penalty, *Agsalud*, *supra*; laws requiring plans to provide pregnancy benefits, *Shaw*, *supra*; and laws requiring employers to provide inactive employees, on workers' compensation, with the same health-benefits as active employees, *District of Columbia v. Greater Washington Board of Trade*, 506 U.S. 125, 129-130 (1992).

The Ninth Circuit's contradiction of this Court's ERISA preemption holdings in *Golden Gate II* is direct and profound. ERISA preempts the San Francisco Ordinance because it creates the same national problems for plan sponsors, plans and ultimately the beneficiaries repeatedly highlighted by this Court's decisions, but doing so to a far-greater degree.

The Ordinance plainly violates the "connection with" prong of ERISA preemption. It compels employers to provide health-benefits to employees, a violation of ERISA's rule that employee benefit plans are to be completely voluntary. The Ordinance also compels employers to choose between maintaining uniformity in health-benefits through a required change in benefits in their existing ERISA plans, or giving up on uniformity through a required provision of different benefits to their San Francisco employees.

Further, an employer must adjust its administrative practices to reflect the Ordinance's unique administrative requirements including rules for coverage of part-time employees working as few as ten-hours-per-week, and for restricting a plan's ability to require employee contributions as part of a health-insurance program. Because employers may not count on "structuring administrative practices according to a set of uniform guidelines," they may "decide to reduce benefits or simply not to pay them at all" in some jurisdictions. *Fort Halifax*, 482 U.S. at 12.

The Ordinance also violates the "connection with" prong because the "City-payment-option" itself requires the creation of an ERISA plan, a point emphasized by the Secretary of Labor's *amicus* brief. App. at 85-86a. ERISA section 3(1) broadly defines an employee welfare benefit plan as including "*any plan, fund, or program*," "established or maintained by an employer," "for the purpose of providing for its participants ... through the *purchase of insurance or otherwise*, medical, surgical, or hospital care or benefits ...." 29 U.S.C. § 1002(1) (emphasis added). The test for ERISA plan coverage is a low-threshold one, designed to sweep as many plans as possible within ERISA's regulation. The test is simply whether the statutory requirements for a "plan, fund, or program" are met, not whether the employer designs the plan or performs all of the work. For example, the employer's day-to-day role in a standard, ERISA-covered group health-plan typically consists of paying premiums and handling a small amount of paperwork.[43] There is no employer-managed trust fund. An insurance

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[43] *See, e.g., Credit Managers Ass'n v. Kennesaw Life & Acc. Ins. Co.*, 809 F.2d 617 (9th Cir. 1987).

company, third-party administrator or PPO performs virtually all of the plan-design, administrative-and-fiduciary tasks, and payment functions. *See, e.g., Brundage-Peterson v. Compcare Health Services Ins. Co.*, 877 F.2d 509, 511 (7th Cir. 1989) ("The contingent feature of a true welfare benefit plan ... is unaffected by the delegation of the administrative duties of the plan to an insurance company—a delegation contemplated by the statute").

Under the "City-payment-option," an employer's ongoing contributions and regulatory compliance establish for its employees an ERISA health "plan, fund, or program" financed "through the purchase of insurance or otherwise." For ERISA's purposes, an employer's HAP-contributions are indistinguishable from its premium payments to an insurance company or a PPO for health-coverage, payments which result in an ERISA plan.[44] In each instance, the employees receive their benefits from a third-party professional administrator and the program is substantially administered by that party.

In concluding the "City-payment-option" was outside of ERISA, the Ninth Circuit contradicted the statute's plain text and Congress's goals. It made the unprecedented holding that for an ERISA plan to exist, not only must there be trust fund assets for ERISA to protect from employer mismanagement, but the employer itself must draft the plan's documents and perform the administrative and fiduciary duties. App. at 20a, 24-26a. This is a classical example of a theory which proves too much. Under this highly-restrictive coverage standard, very few if any

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[44] *See, e.g., Qualls v. Blue Cross of California*, 22 F.3d 839 (9th Cir. 1994).

insured health-plans, third-party-administered plans, or HMO or PPO plans would be governed by ERISA's rules and protections, and few ERISA plans would have professional plan administration.

The Ordinance also violates the "reference to" prong of ERISA preemption. An employer must determine its legal obligations by referring to its existing ERISA plans. This is precisely the situation which triggered preemption in *Washington Board of Trade*, *supra*. The District of Columbia ordinance made an impermissible "reference to" ERISA plans because it required equal health-benefits and therefore required a comparison to ERISA plans.

Similarly, ERISA preempts the Ordinance's healthcare contributions-mandate under *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990). ERISA preempts a claim if, in evaluating it, "the court's inquiry must be directed to the plan." *Id.* at 144. In any City-enforcement action, a court's inquiry must focus on the employer's ERISA plan to see whether it provides contributions equal to Ordinance levels.

B. The Decision's New ERISA Preemption Standard Improperly Allows Local Laws to Regulate Not Just Employer Contributions, But Employee Benefit Plans Themselves

The Ninth Circuit's decision invents an artificial, destructive ERISA preemption standard, one that undermines the Act's primary goals. If local governments may mandate employer contributions and complex administrative schemes, they may regulate ERISA plans themselves by first requiring their establishment and then dictating what benefits the plan provides, what categories of employees and part-

time workers are covered, and how the plan is administered. In addition, plan sponsors must constantly watch for diverse contribution-mandates and administrative regulations across-the-land.

The Ninth Circuit reached this anomalous result through an incorrect ERISA preemption analysis. The court started by observing that laws in areas historically regulated by the states enjoy "a presumption against preemption," citing *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 814 (1997), *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., NA., Inc.*, 519 U.S. 316, 330 (1997), and *Travelers*, *supra*.[45] App. at 13a. In each case, however, the state law was "remote from the areas with which ERISA is expressly concerned" and operated in "'areas where ERISA has nothing to say.'"[46] As applicable here, these cases reflect that ERISA preempts laws, even in areas of traditional local interests, if they have any one of the three features of the "pay-or-play" laws: forbid what ERISA permits, mandate plan structure or administration, or preclude uniform administrative-practices.[47]

The Ninth Circuit then inappropriately applied this presumption-against-preemption to the "pay-or-play" laws. As two other courts correctly concluded in *Fielder*, *supra*, and *Suffolk County*, *supra*, "pay-or-play" mandates aim directly at a quintessential rela-

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[45] *De Buono* simply held that ERISA does not preempt a gross-receipts-tax on healthcare-providers, while *Dillingham* rejected preemption of a prevailing-wage-law. *Travelers* rejected preemption of a surcharge-on-hospital-bills because it did not interfere with nationally-uniform plan administration.

[46] *Egelhoff*, 532 U.S. at 147-148.

[47] *E.g.*, *Travelers*, 514 U.S. at 656-658.

tionship ERISA was meant to govern exclusively: a plan sponsor's arrangements to pay for employees' "medical, surgical, or hospital care or benefits." 29 U.S.C. § 1002(1),

When reviewing mandates for employer contributions or for plan benefits, this Court has uniformly held them to be ERISA-preempted. *See, e.g., Agsalud, supra* (health insurance); *Shaw, supra* (pregnancy benefits); *Washington Board of Trade, supra* (health-benefits); *Stone & Webster Eng'g Corp. v. Ilsley*, 690 F.2d 323 (2d Cir. 1983) (same), *summarily aff'd*, 463 U.S. 1220 (1983). The Ninth Circuit has flatly refused to follow this controlling authority.

The Ninth Circuit based *Golden Gate II* not on the structure, language or purposes of ERISA, much less on this Court's carefully-developed preemption standards. Instead, the court premised its ERISA preemption standard on a spur-of-the-moment, unsupported theory, the type of judicial resolution described by this Court as "bring[ing] on stage, in classic fashion, a *deus ex machina* to extract from ... seemingly insoluble difficulties ... a happy ending."[48] Saving San Francisco's "pay-or-play" law, the Ninth Circuit held that preemption extends only to "mandated-benefits," not "mandated-contributions," and that the latter do not "interfere" with uniformity in plan administration, at least from the perspective of a purely local employer. App. at 35a, 36a-40a. This contributions-benefits distinction is not found anywhere in ERISA or in any prior court decision.

Most significantly, the Ninth Circuit's quixotic distinction between contributions-mandates and benefits-mandates clashes head-on with ERISA's

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[48] *Nevada v. Hicks*, 533 U.S. 353, 416 (2001).

plain text and the Act's principal objectives. It also defies common sense.

Nothing in ERISA's language or in any prior case supports the Ninth Circuit's view that Congress made an inexplicable decision that laws mandating employer contributions for employee benefits were exempt from preemption. 29 U.S.C. § 1144(a) preempts "*any and all*" laws that relate to employee benefit plans, not just some laws.

Employer contributions are not a tangential or peripheral matter, outside of ERISA's concerns. Employer contributions are an indispensable element of employer-financed ERISA plans, no less than gold bullion is to a gold coin. The Ninth Circuit's new contributions-benefits distinction is fanciful-but-illogical. It has a Cheshire-cat, *Alice-in-Wonderland* quality. There may a contribution without a benefit, but never a benefit without a contribution.

For ERISA preemption purposes, there is no material difference between laws mandating employee benefits and laws mandating contributions to pay for benefits. ERISA preempts a contributions-mandate because it overturns, in the same manner as a benefits-mandate, the Act's primary objectives of a voluntary system of cost-effective employee benefit plans[49] under which local laws do not "interfere with nationally uniform plan administration."[50]

Unless reversed, *Golden Gate II* will turn 29 U.S.C. § 1144(a) and this Court's preemption standards into a triviality, a mere semantics-game. A local government may avoid preemption simply by categoriz-

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[49] ERISA section 2(a), 29 U.S.C. § 1001(a)

[50] *Egelhoff*, 532 U.S. at 148.

ing a benefits-mandate as a contributions-mandate, with a government "healthcare-payment" penalty for noncompliance. For example, under the Ninth Circuit's preemption standard, a state may avoid the fate of the statute in *Shaw*, *supra*, by enacting a "contributions-mandate" for pregnancy benefits, coupled with a noncompliance-penalty relabeled a "healthcare-payment." As this Court explained in *Alessi*, 451 U.S. at 525, "ERISA's authors clearly meant to preclude the States from avoiding through form the substance of the pre-emption provision."

The Ninth Circuit's errors are two-fold. The decision allows "pay-or-play" laws to escape the conflicts preemption applicable to other federal statutes under the Supremacy Clause. At the same time, it makes ERISA's express preemption clause less forceful than conflicts preemption. This Court has already squarely rejected such a result in *Boggs v. Boggs*, 520 U.S. 833, 841 (1997) ("We can begin, and in this case end, the analysis by simply asking if state law conflicts with the provisions of ERISA or operates to frustrate its objectives"); *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 397 (2002) (THOMAS, J., dissenting) ("'formalist tricks cannot be sufficient to bypass'" ERISA preemption) (citation omitted).

Unless reversed, the Ninth Circuit's decision will overturn the voluntary nature of ERISA health-plans, remove them from exclusive federal governance, and preclude economical, nationally-uniform plan design, benefits and administration. These are among ERISA's core goals. The decision thus splits the central axis of this Court's ERISA preemption decisions.

C. The Decision Improperly Expands the Type of Government-Mandated Benefit Plans That Are Outside of ERISA's Safeguards

The Ninth Circuit's decision also warrants review because it improperly expands the types of government-mandated benefit plans that are outside of ERISA's safeguards. The decision will engender new confusion and litigation on a significant federal-state issue this Court has sought to resolve several times: under what circumstances do government-mandated benefits cause the creation of an ERISA-covered plan?

This Court has rejected the argument that "ERISA only pre-empts state regulation of pre-existing benefit plans established by the employer, and not state-mandated benefit plans." *Fort Halifax*, 482 U.S. at 16-17. Unless ERISA applied, such mandated-benefit laws would "afford employers a readily available means of evading ERISA's regulatory scope." *Id.* at 16.

For over two decades, this Court has consistently held that government-mandated payments of a type generally regulated by ERISA—such as severance-benefits—escape preemption *only* if the requirement does not create a continuing need to calculate and process the payments on an ongoing basis. *Fort Halifax*, *supra*, held that ERISA does not preempt a state's severance mandate applicable only to plant closures. The payment, a "one-time, lump-sum payment triggered by a single event," required "no administrative scheme whatsoever," while the statute "create[d] no impediment to an employer's adoption of a uniform benefit administration scheme." 482 U.S. at 12, 14.

Similarly, *Massachusetts v. Morash*, 490 U.S. 107, 115 (1989), held that a statute requiring an employer's payment of vacation pay to terminated employees did not create an ERISA plan because the payments, made out of the employer's own assets, were "typically fixed, due at known times, [did] not depend on contingencies outside the employee's control," and did not present risks different from the risk of non-payment of wages. In contrast, the Court explained, in ERISA-covered medical-care plans the benefits "accumulate over a period of time and are payable only upon a contingency outside of the control of the employee." 490 U.S. at 116.

San Francisco's "City-payment-option" involves the creation of an ERISA plan and triggers ERISA preemption because it does far more than require a mere payroll-practice such as cutting a check. All of the Ordinance's options impose ongoing employer payment requirements coupled with a phalanx of administrative chores. As noted in the Secretary of Labor's *amicus* brief, these are precisely the type of administrative requirements that bring a state mandated-benefit plan within ERISA. App. at 87a.

III. THE QUESTION PRESENTED BY THIS PETITION IS ONE OF EXCEPTIONAL NATIONAL IMPORTANCE THAT SHOULD BE ADDRESSED BY THIS COURT.

This Court should review the Ninth Circuit's decision not only because it creates a significant circuit conflict and directly contradicts this Court's ERISA preemption decisions, but also because it raises an issue of exceptional national importance at a time of intensified efforts at federal healthcare-reform. At stake is whether the federal government, or state-and-local powers, will regulate the nation's employee benefit plan system. Unless reversed, the decision will have far-ranging repercussions on this issue and ERISA's most basic objectives.

With the force of a broad-ax, *Golden Gate II* severs ERISA's preemption provision from the Act's principal goals. These include a voluntary employee benefit plan system nationwide whose uniformity and cost-efficiencies are protected by federal law. Simultaneously, the decision uproots well-settled understandings of what constitutes an ERISA plan.

The Ninth Circuit's decision surrenders to the states and countless local municipalities a largely free-rein over the sphere of employee benefit plans. If left standing, the decision will mark the return to a costly, inefficient era when plans were subject to control by fifty different sets of state-law rules and subsets of local regulations. It will resurrect the same obstacles to plan growth and development—the "multiplicity of regulation" and "'conflicting directives'"[51]—that Congress sought to end through ERISA.

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[51] *Travelers*, 514 U.S. at 656-657 (citation omitted).

The employee benefit plan landscape will become far more hostile than before ERISA. While plans and plan sponsors will remain subject to comprehensive ERISA regulation, federal rules will be overlaid with mandates for establishing health-plans and administering them pursuant to conflicting, overlapping and ever-changing state and local regulations. In short time, excessive administration-compliance costs will deplete the employer funds available for benefits, to the detriment of employers and employees alike.

The practical implications of *Golden Gate II* are staggering. As of 2006, healthcare spending totaled approximately 16% of the gross domestic product.[52] Employer-related group health-insurance covers an estimated 177 million individuals.[53] More than nine-out-of-ten employers offer PPO-options and nearly four-out-of-ten offer HMO-options.[54] Unless the decision is reversed, all of these insured group plans, plans with PPO or HMO-options, and self-funded plans with third-party administrators may be subject to "pay-or-play" laws. At the same time, *Golden Gate II*'s highly-restrictive standard for ERISA plan coverage will place the great bulk of these economical off-the-shelf plans outside of ERISA's protections. Further, employers will be able to avoid ERISA's fiduciary duty rules and its civil and criminal enforcement provisions merely by hiring a third-party to perform the bundle of plan-design and administrative-and-fiduciary tasks inherent in any plan. It is difficult to conceive of any law or any

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[52] STATISTICAL ABSTRACT OF THE UNITED STATES: 2009, 96 (128th ed.).

[53] *Id.* at 105.

[54] *Id.* at 24.

decision causing greater damage to the nation's employee benefit plan system.

The nation's vast size makes the problems caused by *Golden Gate II* intolerable. In addition to 50 states, there are over 3,000 counties and more than 35,000 cities and towns.[55] The Ninth Circuit's decision will expose sponsors of multistate plans to a prohibitively-expensive situation: a patchwork-quilt of mandates and regulations coast-to-coast. A single local jurisdiction's power to regulate employee benefit plans becomes the power to overwhelm and destroy the national system of plans if wielded by a series of jurisdictions. This is the same insurmountable burden posed by the earlier influx of state-by-state experiments with employer mandates—dating back to the Hawaii Prepaid Health Care Act—that gave rise to ERISA's broader-than-originally-proposed preemption clause.

If *Golden Gate II* is allowed to stand, sponsors will not be able to establish employee benefit plans voluntarily, much less on an efficient company-wide or nation-wide basis. Instead, they must set up plans and allocate health-expenditures on a haphazard, inefficient person-by-person, location-by-location basis. Sponsors must constantly monitor for new laws in all jurisdictions. There will be a bewildering mismatch of employer contribution rules, either by percentage-of-gross-payroll or a dollar-amount-per-hour-worked. The varying contribution levels themselves may move upwards at uneven rates. Different jurisdictions may require coverage of different categories of employees and part-time workers, and impose different employee contribution requirements or deductibles and

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[55] *Id.* at 259.

co-payments. Compliance with varying employer-contribution formulas and data-compilation and administrative rules will overload the largest human resources departments and the most expensive software-systems.

The Ninth Circuit's decision—coupled with the circuit conflict over ERISA preemption—will also create enormous confusion and difficulty in the design and administration of thousands of employee benefit plans nationwide. Plan sponsors need to know whether they may create plans without fear that a nationally-uniform set of benefits and administrative practices will be overturned in one jurisdiction or another by an unduly-restrictive application of ERISA preemption. It will be impossible for sponsors to predict or even identify the "'uniform body'" of federal benefits law, which is a "basic thrust" of ERISA.[56] Sponsors will not even know which diverging sets of federal and state or local laws to apply in establishing and administering their plans.

This cliff-edge departure from the national uniformity of law required by ERISA, the chaos in plan administration, and the steeply-increased transaction costs will require sponsors to reduce benefits or compensation overall or to eliminate some plans altogether, *Fort Halifax*, 482 U.S. at 13, contrary to the "public interest in encouraging the formation of employee benefit plans," *Pilot Life*, 481 U.S. at 54. None of this promotes the "national public interest" in a voluntary system of employee benefit plans. None of this protects the cost-efficiencies which lie at ERISA's core. None of this furthers ERISA's goals.

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[56] *Travelers*, 514 U.S. at 656-657.

Moreover, the rationale of the Ninth Circuit's decision—that ERISA only preempts mandated-benefits, not mandated-contributions – extends beyond health-benefits. It includes welfare benefits of every stripe. Additionally, states, cities and counties face responsibilities for older residents, many of whom are low-income and may lack significant pensions. If local governments may mandate ongoing employer contributions and administrative schemes for health-benefits, presumably they may also mandate similar ones for pension benefits. Through these devices, local governments may effectively require multistate employers to follow each jurisdiction's unique dictates for establishing and administering ERISA plans providing pension and welfare benefits. All of this is at direct odds with the structure, logic and purpose of ERISA and three decades of Supreme Court precedent.

Swift intervention by this Court is critical to restore the carefully-crafted balance between state and federal law struck by Congress in ERISA and to reestablish the preeminence of ERISA's statutory scheme. Given the "centrality of pension and welfare plans in the national economy," *Boggs v. Boggs*, 520 U.S. at 839, it is vital that this Court decide the significant, far-reaching ERISA preemption issue presented by this case, and resolve the existing circuit conflict.

CONCLUSION

For the foregoing reasons, petitioner urges the Court to grant a writ of certiorari in this case.

Respectfully submitted,

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APPENDIX

APPENDIX A

FOR PUBLICATION

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

No. 07-17370
D.C. No. CV-06-06997-JSW

GOLDEN GATE RESTAURANT, ASSOCIATION,
an incorporated non-profit trade association,
Plaintiff-Appellee,

v.

CITY AND COUNTY OF SAN FRANCISCO,
Defendant,

SAN FRANCISCO CENTRAL LABOR COUNCIL;
SERVICE EMPLOYEES INTERNATIONAL UNION,
HEALTHCARE WORKERS-WEST;
SERVICE EMPLOYEES INTERNATIONAL UNION,
LOCAL 1021; UNITE HERE LOCAL 2,
Defendant-intervenors-Appellants

No. 07-17372
D.C. No. CV-06-06997-JSW OPINION

GOLDEN GATE RESTAURANT, ASSOCIATION,
an incorporated non-profit trade association,
Plaintiff-Appellee,

v.

CITY AND COUNTY OF SAN FRANCISCO,
Defendant,

SAN FRANCISCO CENTRAL LABOR COUNCIL;
SERVICE EMPLOYEES INTERNATIONAL UNION,
HEALTHCARE WORKERS-WEST;
SERVICE EMPLOYEES INTERNATIONAL UNION,
LOCAL 1021; UNITE HERE LOCAL 2,
Defendant-intervenors-Appellants.

Appeal from the United States District Court
for the Northern District of California
Jeffrey S. White, District Judge, Presiding

Argued and Submitted
April 17, 2008—Pasadena, California

Filed September 30, 2008

OPINION

Before: Alfred T. Goodwin, Stephen Reinhardt, and William A. Fletcher, Circuit Judges.

Opinion by Judge William A. Fletcher

W. FLETCHER, Circuit Judge:

Plaintiff Golden Gate Restaurant Association ("the Association") challenges the employer spending requirements of the newly enacted San Francisco Health Care Security Ordinance ("the Ordinance"). The Association argues that the federal Employee Retirement Income Security Act of 1974 ("ERISA") preempts the employer spending requirements of the Ordinance either because those requirements create a "plan" within the meaning of ERISA or because they "relate to" employers' ERISA plans. On December 26, 2007, the district court granted the Associa-

tion's motion for summary judgment and enjoined the implementation of the employer spending requirements. *Golden Gate Rest. Ass'n v. City & County of San Francisco*, 535 F. Supp. 2d 968, 970 (N.D. Cal. 2007). On December 27, 2007, Defendant City and County of San Francisco ("the City") and Defendant-Intervenor labor unions requested that this court stay the judgment of the district court pending appeal. In an order filed January 9, 2008, we granted the stay. *Golden Gate Rest. Ass'n v. City & County of San Francisco* ("*Golden Gate*"), 512 F.3d 1112, 1114 (9th Cir. 2008). We now reach the merits of the appeal. We hold that ERISA does not preempt the Ordinance.

I. Procedural History

In July 2006, the San Francisco Board of Supervisors unanimously passed the San Francisco Health Care Security Ordinance, and the mayor signed it into law. The Ordinance is codified at Sections 14.1 to 14.8 of the City and County of San Francisco Administrative Code. The Ordinance has two primary components: the Health Access Plan ("HAP"), and the employer spending requirements. The HAP[1] is a City-administered health care program. It went into effect in the summer of 2007. In funding the HAP, the City "prioritize[s] services for low and moderate income persons." S.F. Admin. Code § 14.2(d) (2007). According to the City's web page, as of August 9, 2008, 27,395 persons had enrolled in the HAP.[2] Persons who already have health insurance or who live outside of San Francisco are not eligible for the HAP.

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[1] The HAP is now called "Healthy San Francisco."

[2] Healthy San Francisco, about Us, http://www.healthysanfrancisco.org/about_us/Stats.aspx#

Instead, such persons may be entitled to establish medical reimbursement accounts with the City. As we will explain in detail below, the Ordinance also requires all covered employers to make a certain level of health care expenditures on behalf of their covered employees. The Association does not challenge the HAP. It challenges only the employer spending requirements.

The Association filed a complaint against the City on November 8, 2006, asking the district court to declare that ERISA preempts the employer spending requirements, and seeking a permanent injunction against enforcement of the provisions of the Ordinance relating to those requirements. The San Francisco Central Labor Council, Service Employees International Union (SEIU) Local 1021, SEIU United Healthcare Workers-West, and UNITE-HERE! Local 2 (collectively, "Intervenors"), successfully moved to intervene as defendants.

On April 2, 2007, the City deferred implementation of the employer spending requirements until January 1, 2008. On July 13, 2007, the parties filed cross-motions for summary judgment. On December 26, 2007, the district court entered judgment for the Association, concluding that ERISA preempts the employer spending requirements. *See Golden Gate Rest. Ass'n*, 535 F. Supp. 2d at 979-80.

On December 27, 2007, the City and Intervenors asked the district court to stay its judgment pending appeal. The district court denied the motion. On January 9, 2008, this court filed a published order granting the City's motion for a stay of the district court's judgment pending resolution of the City's appeal. *Golden Gate*, 512 F.3d at 1127. Since that

date, covered employers have been required to make quarterly health care expenditures.

On February 7, 2008, the Association filed an application with Justice Kennedy, as Circuit Justice for the Ninth Circuit, for an order vacating our stay of the district court's judgment. On February 21, after receiving the City's response, Justice Kennedy denied the application. The United States Secretary of Labor subsequently filed an *amicus* brief in this court in support of the Association.

On April 17, 2008, we heard oral argument on the merits of the City's appeal. We now reverse the judgment of the district court and remand with instructions to enter summary judgment in favor of the City and Intervenors.

II. Standard of Review

"We review *de novo* the district court's grant of summary judgment and, viewing the evidence in the light most favorable to the non-moving party, determine whether there are any genuine issues of material fact for trial." *In re Syncor ERISA Litig.*, 516 F.3d 1095, 1100 (9th Cir. 2008). "ERISA preemption is a question of law, which we also review *de novo*." *Elliot v. Fortis Benefits Ins. Co.*, 337 F.3d 1138, 1141 (9th Cir. 2003).

III. The Ordinance

The Ordinance mandates that covered employers make "required health care expenditures to or on behalf of certain employees each quarter. S.F. Admin. Code § 14.3(a). "Covered employers" are employers engaging in business within the City that have an average of at least twenty employees performing work for compensation during a quarter, and non-

profit corporations with an average of at least fifty employees performing work for compensation during a quarter. *Id.* § 14.1(b)(3), (11), (12). "Covered employees" are individuals who (1) work in the City, (2) work at least ten hours per week, (3) have worked for the employer for at least ninety days, and (4) are not excluded from coverage by other provisions of the Ordinance. *Id.* § 14.1(b)(2).

The Ordinance sets the required health care expenditure for employers based on the Ordinance's "health care expenditure rate." *Id.* §§ 14.1(b)(8), 14.3(a). For-profit employers with between twenty and ninety-nine employees and non-profit employers with fifty or more employees must make health care expenditures at a rate of $1.17 per hour. For-profit employers with one hundred or more employees must make expenditures at a rate of $1.76 per hour. *See* City & County of San Francisco, Office of Labor Standards Enforcement, Regulations Implementing the Employer Spending Requirement of the San Francisco Health Care Security Ordinance ("ESR"), Reg. 5.2(A) (2007).[3] Under the Ordinance, "[t]he required health care expenditure for a covered employer shall be calculated by multiplying the total number of hours paid for each of its covered employees during the quarter . . . by the applicable health care expenditure rate." S.F. Admin. Code § 14.3(a).

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[3] On June 16, 2008, the City issued revised ESR regulations. Those revisions do not pertain to any of the regulations discussed in this opinion. *See* City & County of S.F. Office of Labor Standards Enforcement, Regulations Implementing the Employer Spending Requirement of the San Francisco Health Care Security Ordinance (June 16, 2008), *available at* http://www.sfgov.org/site/uploadedfiles/olse/hcso/ HCSO Final Regulations.pdf.

Regulations implementing the Ordinance specify that "[a] health care expenditure is any amount paid by a covered employer to its covered employees or to a third party on behalf of its covered employees for the purpose of providing health care services for covered employees or reimbursing the cost of such services for its covered employees." ESR Reg. 4.1(A). A "covered employer has discretion as to the type of health care expenditure it chooses to make for its covered employees." ESR Reg. 4.2(A). Section 14.1(b)(7) of the Ordinance specifies that the definition of health care expenditure includ[es], but [is] not limited to

> (a) contributions by [a covered] employer on behalf of its covered employees to a health savings account as defined under section 223 of the United States Internal Revenue Code or to any other account having substantially the same purpose or effect without regard to whether such contributions qualify for a tax deduction or are excludable from employee income;
>
> (b) reimbursement by such covered employer to its covered employees for expenses incurred in the purchase of health care services;
>
> (c) payments by a covered employer to a third party for the purpose of providing health care services for covered employees;
>
> (d) costs incurred by a covered employer in the direct delivery of health care services to its covered employees; and
>
> (e) payments by a covered employer to the City to be used on behalf of covered employees. The City may use these payments to:

> (i) fund membership in the Health Access Program for uninsured San Francisco residents; and
>
> (ii) establish and maintain reimbursement accounts for covered employees, whether or not those covered employees are San Francisco residents.

S.F. Admin. Code § 14.1(b)(7) (paragraphing added); *see also* ESR Reg. 4.2(A).

If an employer does not make required health care expenditures on behalf of employees in some other way, it may meet its spending requirement by making payments directly to the City under § 14.1(b)(7)(e). *See* ESR Reg. 4.2(A). We refer to this option as the City-payment option. If an employer elects the City-payment option, its covered employees who satisfy age and income requirements and are "uninsured San Francisco residents" may enroll in the HAP, and its other covered employees will be eligible for medical reimbursement accounts with the City. Covered employees may enroll in the HAP free of charge or at reduced rates. The HAP provides enrollees with "medical services with an emphasis on wellness, preventive care and innovative service delivery." S.F. Admin. Code § 14.2(f). A primary care provider at the enrollee's "medical home" "develop[s] and direct[s] a plan of care for each [HAP] participant." *Id.* § 14.2(e). Enrollees pay income-based "participation fees" and "point-of-service fees." Regulations Implementing Health San Francisco and Medical Reimbursement Account Provisions of the San Francisco Health Care Security Ordinance, Reg. 4(a) (2007).

An employer is exempt from making payments to the City if it makes health care expenditures under

§ 14.1(b)(7)(a)-(d) of at least $1.17 or $1.76 per hour (depending on the nonprofit or for-profit status of the employer, and on the number of employees), and it is partially exempt to the extent that it makes lesser expenditures.

The Ordinance requires covered employers to "maintain accurate records of health care expenditures, required health care expenditures, and proof of such expenditures made each quarter each year," but it does not require them "to maintain such records in any particular form." S.F. Admin. Code § 14.3(b)(i). Employers must provide the City with "reasonable access to such records." *Id.* If an employer fails to comply with these requirements, the City will "presume[ ] that the employer did not make the required health expenditures for the quarter for which records are lacking, absent clear and convincing evidence otherwise." *Id.* § 14.3(b)(ii).

The Ordinance includes a special provision for employers with self-insured health plans. An employer providing "health coverage to some or all of its covered employees through a self-funded/self-insured plan" will "comply with the spending requirement . . . if the preceding year's average expenditure rate per employee meets or exceeds the applicable expenditure rate" for the employer. ESR Reg. 6.2(B)(2). Such employers do not need to keep track of their actual expenditures for each employee.

Relevant to our analysis, there are five categories of employers under the Ordinance. First are employers that have no ERISA plans ("No Coverage Employers"). Second are employers that have ERISA plans for all employees, and that spend at least as much as the Ordinance's required health care expenditure per employee ("Full High Coverage

Employers"). Third are employers that have ERISA plans for some, but not all, employees, and that spend at least as much as the Ordinance's required health care expenditure per employee for employees under the ERISA plan ("Selective High Coverage Employers"). Fourth are employers that have ERISA plans for all employees, but that spend less than the Ordinance's required health care expenditure per employee ("Full Low Coverage Employers"). Fifth are employers that have ERISA plans for some, but not all, employees, and that spend less than the Ordinance's required health care expenditure per employee for employees under the ERISA plan ("Selective Low Coverage Employers").

No Coverage Employers may choose to continue without any ERISA plans. In that event, they can make their required health care expenditures directly to the City. *See* ESR Reg. 4.2(A)(6). If these employers choose, instead, to establish an ERISA plan, the Ordinance requires only that they make the required level of health care expenditures. They can do so by paying the full amount to the plan, or by paying part to the plan and part to the City. The Ordinance does not dictate which employees must be eligible for the plan, or what benefits a plan must provide. *See* ESR Reg. 4.2(A)(1)-(5).

Full High Coverage Employers may choose to leave their ERISA plans intact and unaltered. So long as they maintain records to show that they are making the required health care expenditures, they comply with the Ordinance.

Selective High Coverage Employers may choose to leave their ERISA plans intact and unaltered. In that event, for employees not covered by their ERISA plans, they can comply with the Ordinance by mak-

ing the required health care expenditures to the City. *See* ESR Reg. 6.2(C) ("An employer may . . . choose to purchase health insurance for its full-time employees, but make payment to the City to fund part-time employees' membership in the Health Access Program[.]").

Full Low Coverage Employers may choose to leave their ERISA plans intact and unaltered. In that event, they can comply with the Ordinance by making payments to the City in an amount equal to the difference between their expenditures for the ERISA plans and the required health care expenditures under the Ordinance. *See* ESR Reg. 6.2(D) ("[A]n employer who purchases a health insurance program with premiums that are less than the required expenditure . . . may choose to pay the remainder to the City to establish and maintain medical reimbursement accounts for such employees.").

Selective Low Coverage Employers may choose to leave their ERISA plans intact and unaltered. In that event, they can comply with the Ordinance for employees enrolled in their ERISA plans by paying to the City the difference between their expenditures for the plans and the required health care expenditures under the Ordinance, and for employees not enrolled in their ERISA plans by paying to the City the full amount of the required health care expenditures.

We make two observations about the Ordinance. First, the Ordinance does not require employers to establish their own ERISA plans or to make any changes to any existing ERISA plans. Employers may choose to make up the difference between their existing health care expenditures and the minimum expenditures required by the Ordinance either by altering existing ERISA plans or by establishing new

ERISA plans. However, they need not do so. The City-payment option allows employers to make payments directly to the City, if they so choose, without requiring them to establish, or to alter existing, ERISA plans. If employers choose to pay the City, the employees for whom those payments are made are entitled to receive either discounted enrollment in the HAP or medical reimbursement accounts with the City.

Second, the Ordinance is not concerned with the nature of the health care benefits an employer provides its employees. It is only concerned with the dollar amount of the payments an employer makes toward the provision of such benefits. An employer can satisfy its spending requirements by paying the City; it can satisfy those requirements by funding exclusively preventive care; it can satisfy those requirements by setting up an on-site clinic and reimbursing employees for the purchase of over-the-counter medications; or it can satisfy those requirements in some other manner, such as funding a traditional ERISA plan. The Ordinance does not look beyond the dollar amount spent, and it does not evaluate benefits derived from those dollars.

IV. Discussion

The Association argues that ERISA preempts the Ordinance either because it creates a "plan" within the meaning of ERISA or because it "relates to" employers' ERISA plans within the meaning of ERISA. For the reasons that follow, we disagree.

Crafted as a compromise between employers and employees, ERISA has two primary purposes. First, from the perspective of employees and other beneficiaries of ERISA plans, "ERISA was passed by Con-

gress in 1974 to safeguard employees from the abuse and mismanagement of funds that had been accumulated to finance various types of employee benefits." *Massachusetts v. Morash*, 490 U.S. 107, 112 (1989). "In enacting ERISA, Congress' primary concern was with the mismanagement of funds accumulated to finance employee benefits and the failure to pay employees benefits from accumulated funds. To that end, it established extensive reporting, disclosure, and fiduciary duty requirements to insure against the possibility that the employee's expectation of the benefit would be defeated through poor management by the plan administrator." *Id.* at 115 (citation and footnote omitted). Second, from the perspective of employers, "[t]he purpose of ERISA is to provide a uniform regulatory regime over employee benefit plans." *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004). Uniformity of regulation eases the administrative burdens on employers and plan administrators, thereby reducing costs to employers.

A. Presumption Against Preemption

We begin by noting that state and local laws enjoy a presumption against preemption when they "clearly operate[ ] in a field that has been traditionally occupied by the States." *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 814 (1997) (internal quotation marks omitted). This presumption informs our preemption analysis. *See Boggs v. Boggs*, 520 U.S. 833, 840 (1997) (the fact that a state law "implement[s] policies and values lying within the traditional domain of the States . . . inform[s] [a] preemption analysis"). The presumption against preemption applies in ERISA cases. "[N]othing in the language of [ERISA] or the context of its passage indicates that Congress chose to displace general

health care regulation, which historically has been a matter of local concern." *N. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 661 (1995). "[T]he Court has established a presumption that Congress did not intend ERISA to preempt areas of traditional state regulation that are quite remote from the areas with which ERISA is expressly concerned—reporting, disclosure, fiduciary responsibility, and the like." *Rutledge v. Seyfarth, Shaw, Fairweather & Gerald. von*, 201 F.3d 1212, 1217 (9th Cir. 2000) (emphasis in original; internal quotation marks omitted). Further, "ERISA preemption must have limits when it enters areas traditionally left to state regulation—such as the state's . . . regulation of health . . . matters." *Operating Eng'rs Health & Welfare Trust Fund v. JWJ Contracting Co.*, 135 F.3d 671, 677 (9th Cir. 1998).

The field in which the Ordinance operates is the provision of health care services to persons with low or moderate incomes. State and local governments have traditionally provided health care services to such persons. *See* Paul Star, *The Social Transformation of American Medicine* 185 (1982) (noting that other than the four-year period from 1879 to 1883, when there was a National Board of Health, "public health remained almost entirely a state and local responsibility"); *id.* at 181-82 (describing "the role of public dispensaries in treating the sick poor"); *id.* at 169 (describing the first phase of the hospital system in the United States, spanning 1751 to 1850, in which there were charitable hospitals "and public hospitals, descended from almshouses and operated by municipalities [and] by counties"); *id.* at 171 (noting that "[p]ublic hospitals generally treated the poor [and] relied on government appropriations rather than fees"). The Ordinance uses a novel

approach to the provision of health services to such persons, but operates in a field that has long been the province of state and local governments, thereby "implement[ing] policies and values lying within the traditional domain of the States." *Boggs*, 520 U.S. at 840.

B. Preemption Under ERISA

ERISA governs "employee benefit plans," including "employee welfare benefit plans." 29 U.S.C. § 1002(3). Section 514(a) of ERISA states that ERISA preempts "any and all State laws insofar as they . . . relate to any employee benefit plan" governed by ERISA. 29 U.S.C. § 1144(a). "A law 'relate[s] to' a covered employee benefit plan for purposes of § 514(a) if it [1] has a connection with or [2] reference to such a plan." *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., NA., Inc.* ("*Dillingham*"), 519 U.S. 316, 324 (1997) (alterations in original; some internal quotation marks omitted).

The Association and the amicus, the Secretary of Labor, make two central arguments. First, they argue that the City-payment option under the Ordinance creates an ERISA plan. This argument takes two forms. The Association argues in its brief that the Ordinance's administrative obligations on employers, in combination with a reasonable person's ability to ascertain "benefits, beneficiaries, source of financing, and procedures for receiving benefits," creates an ERISA plan. The Secretary of Labor argues as amicus that the HAP itself is an ERISA plan. If either argument is correct, the Ordinance almost certainly makes an impermissible "reference to" an ERISA plan. Second, they argue that even if the City-payment option does not establish an ERISA plan, an employer's obligation to make payments at a

certain level—whether or not the payments are made to the City—"relates to" the ERISA plans of covered employers and is thus preempted. We address these arguments in turn.

1. The City Payment Option Does Not Create an ERISA "Plan"

If the City-payment option does not create an "employee welfare benefit plan" within the meaning of ERISA, the first argument fails. The district court concluded that employers' payments to the City do not create an ERISA plan. *See Golden Gate Rest. Ass'n*, 535 F.Supp. 2d at 976 (Ordinance does not "create[ ] a separate *de facto* ERISA plan"). For the reasons that follow, we agree with the district court and hold that the City-payment option does not create an ERISA plan, *de facto* or otherwise. We first address the Association's argument. We then address the Secretary's argument.

a. Employers' Administrative Obligations, and the Ability to Ascertain Benefits, Beneficiaries, Financing and Procedures

The first element of an employee welfare benefit plan is the existence of a "plan, fund or program." *Patelco Credit Union v. Sahni*, 262 F.3d 897, 907 (9th Cir. 2001). In the context of ERISA, the phrase "plan, fund or program" is a term of art. As relevant to this case, an ERISA "plan" is an "employee welfare benefit plan," defined as

> [a]ny plan, fund, or program which . . . is . . . established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the pur-

> pose of providing for its participants . . . , through the purchase of insurance or otherwise, . . . medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment . . .

29 U.S.C. § 1002(1); *see also* § 1002(3); *Patelco Credit Union*, 262 F.3d at 907.

> The Supreme Court has emphasized that ERISA is concerned with "benefit plans," rather than simply "benefits," because "[o]nly 'plans' involve administrative activity potentially subject to employer abuse." *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 16 (1987). This focus on "benefit plans" is consistent with the first underlying purpose of ERISA — protecting employees against the abuse and mismanagement of funds. If an employee's expectation of a "benefit" presents "a danger of defeated expectations [that] is no different from the danger of defeated expectations of wages for services performed," then the employer's actions giving rise to that expectation do not amount to a "benefit plan" because such danger is one "Congress chose not to regulate in ERISA." *Morash*, 490 U.S. at 115.

Two Supreme Court cases tell us that an employer's obligation to make monetary payments based on the amount of time worked by an employee,

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over and above ordinary wages, does not necessarily create an ERISA plan. This is so even if the payments are made by the employer directly to the employees who are the beneficiaries of the putative "plan." First, in *Fort Halifax*, a Maine statute required an employer to pay employees one week's pay for every year worked if the employees were terminated because of a plant closing. The Court held that the statute did not create a "plan" within the meaning of ERISA: "The Maine statute neither establishes, nor requires an employer to maintain, an employee benefit *plan*. The requirement of a onetime, lump-sum payment triggered by a single event requires no administrative scheme whatsoever to meet the employer's obligation." *Id.* at 12.

Second, in *Massachusetts v. Morash*, 490 U.S. 107, 109 (1989), a Massachusetts statute required employers to pay discharged employees their "full wages, including holiday or vacation payments, on the date of discharge." The Court held that the statute was not preempted by ERISA. The Court wrote, "It is unlikely that Congress intended to subject to ERISA' s reporting and disclosure requirements those vacation benefits which by their nature are payable on a regular basis from the general assets of the employer and are accumulated over time only at the election of the employee." *Id.* at 116. The Court in *Morash* emphasized the importance of the fact that the employer made the payments out of its general assets:

> An entirely different situation would be presented if a separate fund had been created by a group of employers to guarantee the payment of vacation benefits to laborers who regularly shift their jobs from one employer to another. Em-

> ployees who are beneficiaries of such a trust face far different risks and have far greater need for the reporting and disclosure requirements that the federal law imposes than those whose vacation benefits come from the same fund from which they receive their paychecks.

Id. at 120.

The employer payments at issue under the San Francisco Ordinance, which the Association contends create an ERISA plan, are not made directly to employees. Rather, they are made to the City. But even if the employers made the payments directly to the employees, *Fort Halifax* and *Morash* indicate that those payments would not be enough to create an ERISA plan. Under the Ordinance, employers make the payments on a regular periodic basis and calculate those payments based on the number of hours worked by the employee. Further, as in *Morash*, employers make the payments "on a regular basis from [their] general assets." If employers made the payments directly to the employees, there would be little to differentiate those payments from wages paid to employees. Indeed, the City allows employers to pay the City on a weekly, bi-weekly, or monthly basis, so that employers may coordinate their payments under the Ordinance with their employees' regular pay periods. *See* ESR Reg. 6.2(A)(2).

The fact that an employer makes its payments to the City rather than to the employees confirms, if confirmation were needed, that the employer's administrative obligations under the City-payment option do not create an ERISA plan. Under the Ordinance, an employer has no responsibility other than to make the required payments for covered employees, and to retain records to show that it has

done so. The payments are made for a specific purpose, but the employer has no responsibility for ensuring that the payments are actually used for that purpose. The Association points to the burden entailed in keeping track of which workers perform qualifying work in San Francisco, keeping track of the hours those employees work, and keeping track of the credit (if any) an employer should get for health care payments made to non-City entities. This burden is not enough, in itself, to make payment obligation an ERISA plan. Many federal, state and local laws, such as income tax withholding, social security, and minimum wage laws, impose similar administrative obligations on employers; yet none of these obligations constitutes an ERISA plan.

We have emphasized that an employer's administrative duties must involve the application of more than a modicum of discretion in order for those administrative duties to amount to an ERISA plan. It is within the exercise of that discretion that an employer has the opportunity to engage in the mismanagement of funds and other abuses with which Congress was concerned when it enacted ERISA. In *Bogue v. Ampex Corp.*, 976 F.2d 1319, 1323 (9th Cir. 1992), we concluded that the employer, in determining whether an employee was eligible for severance pursuant to an employment agreement, "was obligated to apply enough ongoing, particularized, administrative, discretionary analysis to make the [severance] program in this case a 'plan.'" In *Velarde v. Pace Membership Warehouse, Inc.*, 105 F.3d 1313, 1317 (9th Cir. 1997), we emphasized that in order to amount to a "plan," the agreement must require the employer to apply more than "some modicum of discretion." There must be "*enough* ongoing, particularized, administrative, discretionary analysis to make

the plan an ongoing administrative scheme." *Id.* (emphasis in original; citation and internal quotation marks omitted).

An employer's administrative obligations under the City-payment option do not run the risk of mismanagement of funds or other abuse. To be sure, employers must keep track of the number of hours their employees work and whether those hours are worked in San Francisco or elsewhere. Employers must also determine whether particular employees are "supervisorial" or "managerial," and thereby not covered employees. S.F. Admin. Code § 14.1(b)(2)(d). An employer may have some incentive to minimize the number of covered employees or the number of reported hours worked in San Francisco, but the employer has no discretion under the Ordinance to alter its books to reduce its quarterly spending obligation. Rather, the employer's administrative obligations involve mechanical record-keeping, and the employer's payments to the City "are typically fixed, due at known times, and do not depend on contingencies outside the employee's control." *Morash*, 490 U.S. at 115. Any potentially subjective judgments involved with making these calculations and maintaining these records amount to nothing more than the exercise of "a modicum of discretion."

The Association contends that the administrative burden on the covered employers, combined with the reasonable ascertainability of benefits to employees, creates an ERISA plan. The Association contends that the employer's obligation to make payments to the City satisfies the criteria for a plan set forth in *Donovan v. Dillingham*, 688 F.2d 1367, 1370-73 (11th Cir. 1982) (en banc). Quoting *Donovan*, the Association argues, "Plan creation requires only that 'a rea-

sonable person could ascertain the intended benefits, beneficiaries, source of financing, and procedures for receiving benefits.' *Donovan*, 688 F.2d at 1373." We have relied on these criteria from *Donovan* in three primary circumstances in this circuit: in *Scott v. Gulf Oil Corp.*, 754 F.2d 1499 (9th Cir. 1985), in *Modzelewski v. Resolution Trust Corp.*, 14 F.3d 1374 (9th Cir. 1994), and in *Winterrowd v. American General Annuity Ins. Co.*, 321 F.3d 933 (9th Cir. 2003).

In *Scott*, we relied on the criteria set forth in *Donovan* to hold that an agreement to provide severance pay to terminated employees at a rate of two weeks' salary for each year of employment was sufficient to establish an ERISA plan. 754 F.2d at 1503-04. The outcome of *Scott* is almost certainly no longer good law in light of the Supreme Court's subsequent decisions in *Fort Halifax* and *Morash*.

In *Modzelewski*, we set forth the *Donovan* factors in determining whether an employer's promise to pay its employees monthly installments upon retirement amounted to a de facto pension plan. 14 F.3d at 1376. We concluded that "Because ERISA's definition of a pension plan is so broad, virtually any contract that provides for some type of deferred compensation will also establish a de facto pension plan." 14 F.3d at 1377. Because ERISA's definition of "employee pension benefit plan" is distinct from its definition of "employee welfare benefit plan," *Modzelewski* is not relevant to our analysis here. *See* 29 U.S.C. § 1002(1), (2)(A); *see also Carver v. Westinghouse Hanford Co.*, 951 F.2d 1083, 1086 (9th Cir. 1991).

In *Winterrowd*, we held that an accepted offer to provide termination benefits was not sufficiently specific in describing benefits to satisfy the *Donovan* cri-

teria, and that the offer therefore did not constitute an ERISA plan. 321 F.3d at 939. We did not hold in *Winterrowd* that an agreement satisfying the *Donovan* criteria, without more, constituted an ERISA plan. Rather, we held that an agreement not satisfying the *Donovan* criteria did not constitute an ERISA plan. In other words, satisfying the *Donovan* criteria was a necessary but not sufficient condition for the creation of an ERISA plan. *See Curtis v. Nev. Bonding Coip.*, 53 F.3d 1023, 1028 (9th Cir. 1995) (concluding that the *Donovan* criteria were not satisfied, and noting that "our court has not yet determined the minimum requirements for establishing the existence of an ERISA plan"); *see also Cinelli v. Sec. Pac. Corp.*, 61 F.3d 1437, 1442-44 (9th Cir. 1995) (concluding that because the *Donovan* criteria were not present there was no de facto employee welfare benefit plan).

The Association has not cited, and we have not discovered, any cases in which this court has applied the *Donovan* criteria to an employer's administrative obligations imposed by a state or local law. All of the cases applying the *Donovan* criteria address the question whether an informal, or de facto, ERISA plan has been established, and all involve some type of unwritten or informal promise made by an employer to its employees. We would be very hesitant to hold that the *Donovan* criteria apply to statutory administrative burdens imposed on an employer where, as here, that employer has made no promises whatsoever to its employees, which is what the Association urges us to do. We share the view expressed by the Seventh Circuit in *Sandstrom v. Cultor Food Science, Inc.*, 214 F.3d 795 (7th Cir. 2000):

> It is not clear that the approach taken in *[Donovan]* is compatible with more recent decisions of the Supreme Court, which emphasize different considerations when asking whether an informal policy or arrangement is a "plan." Both *Morash* and *Ft. Halifax* evince reluctance to find that regular and predictable awards of severance or vacation payments establish a "plan," given the frequency with which these benefits are the subject of bilateral negotiations between employers and departing employees.

Id. at 797 (citations omitted).

But we need not reach the question whether *Donovan* applies, for, in any event, its criteria are not satisfied. For employers who choose to make payments to the City, their obligation ceases as soon as they make the required payments. If an employer has made such payments to the City under the Ordinance, covered employees may enroll in the HAP free of charge or at a discounted rate. But as we will explain in more detail in a moment, there is nothing in the Ordinance that guarantees that a certain level or kind of "intended benefits" will be provided by the HAP, or that a particular group of "intended . . . beneficiaries" will be included in the HAP.

b. The HAP as an ERISA Plan

The Association expressly stated in its complaint that it "wholeheartedly supports the San Francisco Health Access Program and its laudable goals." It requested that the district court "issue declaratory and injunctive relief *without* disturbing all other lawful parts of the Ordinance unrelated to" the employer spending requirement. (Emphasis in original.) The Secretary of Labor, as *amicus curiae*, argues that the

HAP itself is an ERISA plan. If the Secretary is right, ERISA preempts not merely the employer spending requirements, but the HAP itself. We need not consider arguments raised solely by an *amicus*, particularly when they were not raised before the district court and when they are in tension with the strategic positions taken by the litigants. *See Russian River Watershed Prot. Comm. v. City of Santa Rosa*, 142 F.3d 1136, 1141 n.1 (9th Cir. 1998). Further, we need not consider arguments raised for the first time on appeal. *Choe v. Torres*, 525 F.3d 733, 740 n.9 (9th Cir. 2008). We address the Secretary's argument to indicate our disagreement with it, but we do not concede the correctness of the Secretary's implicit assumption that the argument is properly before us.

As described in greater detail above, the first element of an employee welfare benefit plan is the existence of a "plan, fund or program." *Patelco Credit Union*, 262 F.3d at 907. The HAP, administered by the City, is not an ERISA plan. Rather, the HAP is a government entitlement program available to low- and moderate-income residents of San Francisco, regardless of employment status.[4] It is funded pri-

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[4] The Secretary also argues that the HAP operates as "a government-run program for private employers," and therefore it is not entitled to the exemption under 29 U.S.C. § 1003(b)(1) from ERISA regulations. The ERISA exemption to which the Secretary refers applies when a government establishes and maintains an employee welfare benefit plan for its own employees. *See id.*; *see also* 29 U.S.C. § 1002(32). As the Secretary correctly notes, a government plan of that type loses its exemption when it opens up its plan to employees of private employers. The Secretary's argument is that the City has opened its exempt plan for its own employees to private employees and has thus forfeited its exemption. The Secretary's argument is without

marily by taxpayer dollars. Employer payments under the Ordinance provide only a small portion of the HAP's funding, and, although we do not know the precise numbers, employees covered under the Ordinance comprise substantially less than half of all HAP enrollees. The fact that a minority of HAP enrollees pay a discounted enrollment fee because their employers participate in the City-payment option is not enough to make the HAP a "plan, fund or program" within the meaning of ERISA. *See Waks v. Empire Blue Cross/Blue Shield*, 263 F.3d 872, 875 (9th Cir. 2001) (concluding that a converted individual policy was not itself an ERISA plan because the policy "covered [the plaintiff] as an individual and not as an employee of . . . any . . . employer").

The second element of an employee welfare benefit plan requires that the plan be "established or maintained by an employer through the purchase of insurance or otherwise." *Patelco Credit Union*, 262 F.3d at 907. An employer electing the City-payment option does not "establish[ ] or maintain[ ]" the HAP through its payments. The HAP exists, and will continue to exist, whether or not any covered employer makes a payment to the City under the Ordinance. Further, the employer has no control over whether its employees are eligible for the HAP. Under the terms of the ordinance, HAP eligibility is based on income level, age, uninsured status, and City residence, but the City is free to change the conditions of eligibility for HAP enrollment as it sees fit simply by amending

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foundation. The City does maintain an exempt employee welfare benefit plan for its own employees. The HAP, however, is not that plan. The City has never argued that the HAP is exempt from ERISA as a government-run plan for the City's own employees.

the Ordinance. Finally, neither the employer nor the covered employee has any control over the kind and level of benefits provided by the HAP. The employer never negotiates or signs a contract with the City, and the employer has no control over the City's coverage decisions. When the City administers the HAP, it does not act as the employer's agent entrusted to fulfill the benefits promises the employer made to its employees. An employer can make no promises to its employees with regard to the HAP or its coverage. In short, the City, rather than the employer, establishes and maintains the HAP, and the City is free to change the kind and level of benefits as it sees fit.

2. "Relates to" Employers' ERISA Plans

The Association's and the Secretary of Labor's second argument is that, even if the City-payment option does not create an ERISA plan, the Ordinance is preempted because it "relates to" *employers'* ERISA plans. 29 U.S.C. § 1144(a).

1131 Section 514(a) of ERISA states that ERISA preempts "any and all State laws insofar as they . . . relate to any employee benefit plan" governed by ERISA. 29 U.S.C. § 1144(a). The Supreme Court has established a two-part inquiry to interpret § 514(a): "A law 'relate[s] to' a covered employee benefit plan for purposes of § 514(a) if it [1] has a connection with or [2] reference to such a plan." *Dillingham*, 519 U.S. at 324 (alterations in original) (some internal quotation marks omitted). We consider these two inquiries in turn.

a. "Connection with" a Plan

In *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, 514 U.S.

645, 655 (1995), the Court acknowledged the difficulty of interpreting § 514(a):

> If "relate to" were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course . . . But that, of course, would be to read Congress's words of limitation as mere sham, and to read the presumption against pre-emption out of the law whenever Congress speaks to the matter with generality.

Likewise, the Court recognized that the two-part inquiry it had adopted to interpret § 514(a) did not provide much additional guidance in cases hinging on a law's "connection with an employee benefit plan. "For the same reasons that infinite relations cannot be the measure of pre-emption, neither can infinite connections." *Id.* at 656.

We read *Travelers* as narrowing the Court's interpretation of the scope of § 514(a). The Court reasoned it had to "go beyond the unhelpful text and the frustrating difficulty of defining [§ 514(a)'s] key term, and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." *Id.*; *see also Gerosa v. Savasta & Co.*, 329 F.3d 317, 327 (2d Cir. 2003) (discussing how, among the circuits, the *Travelers* decision "occasioned a significant change in preemption analysis, and required careful reconsideration of any preexisting precedent dependent on the expansive view of 'related to' that held sway before it"). In this light, we employ a "holistic analysis guided by congressional intent." *Dishman v. UNUM Life Ins. Co. of Am.*, 269 F.3d 974, 981 n.15 (9th Cir. 2001); *see e.g., Egelhoff v. Egelhoff*, 532 U.S. 141, 147 (2001).

As noted above, one "purpose of ERISA is to provide a uniform regulatory regime over employee benefit plans." *Davila*, 542 U.S. at 208. The purpose of ERISA's preemption provision is to "ensure[ ] that the administrative practices of a benefit plan will be governed by only a single set of regulations." *Fort Halifax Packing Co.*, 482 U.S. at 11. In *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990), the Court explained that

> Section 514(a) was intended to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government. Otherwise, the inefficiencies created could work to the detriment of plan beneficiaries.

In furtherance of ERISA' s goal of ensuring that "plans and plan sponsors [are] subject to a uniform body of benefits laws," the Court in *Egelhoff v. Egelhoff*, 532 U.S. 141 (2001), struck down a Washington State law that directed a choice of beneficiary that conflicted with the choice provided in an ERISA plan. The Court held that a state or local law has an impermissible "connection with" ERISA plans where it "binds ERISA plan administrators to a particular choice of rules for determining beneficiary status[,] . . . rather than [allowing administrators to pay the benefits] to those identified in the plan documents." *Id.* at 147. Similarly, in *Shaw v. Delta Air Lines*, 463 U.S. 85, 97-100 (1983), the Court held that ERISA preempts state laws "which prohibit[ ] employers from structuring their employee benefit plans" in a particular manner or "which require[ ] employers to pay employees specific benefits."

Consistent with these later-decided cases, in *Standard Oil Co. v. Agsalud*, 633 F.2d 760, 763 (9th Cir. 1980), *aff'd mem.*, 454 U.S. 801 (1981), we struck down a Hawaii statute that "require[d] employers in that state to provide their employees with a comprehensive prepaid health care plan." As the district court noted, the statute required that plan benefits include "a combination of features," and specifically "require[d] that the plans cover diagnosis and treatment of alcohol and drug abuse." *Standard Oil Co. v. Agsalud*, 442 F.Supp. 695, 696, 704 (N.D. Cal. 1977). The statute also imposed "certain reporting requirements which differ[ed] from those of ERISA." *Id.* at 696. In affirming the district court's opinion holding the Hawaii statute preempted under ERISA, we emphasized that the statute "directly and expressly regulate[d] employers and the *type of benefits they provide* employees," and that it therefore "related to" ERISA plans under § 514(a). *Agsalud*, 633 F.2d at 766 (emphasis added). That is, the Hawaii statute was preempted because it required employers to have health plans, and it dictated the specific benefits employers were to provide through those plans. *Id.* The statute thereby impeded ERISA's goal of ensuring that "plans and plan sponsors would be subject to a uniform body of benefits law." *Ingersoll-Rand Co.*, 498 U.S. at 142.

The Ordinance in this case stands in stark contrast to the laws struck down in *Egelhoff*, *Shaw* and *Agsalud*. The Ordinance does not require any employer to adopt an ERISA plan or other health plan. Nor does it require any employer to provide specific benefits through an existing ERISA plan or other health plan. Any employer covered by the Ordinance may fully discharge its expenditure obligations by making the required level of employee

health care expenditures, whether those expenditures are made in whole or in part to an ERISA plan, or in whole or in part to the City. The Ordinance thus preserves ERISA's "uniform regulatory regime." *See Davila*, 542 U.S. at 208. The Ordinance also has no effect on "the administrative practices of a benefit plan," *Fort Halifax Packing Co.*, 482 U.S. at 11, unless an employer voluntarily elects to change those practices.

A covered employer may choose to adopt or to change an ERISA plan in lieu of making the required health care expenditures to the City. An employer may be influenced by the Ordinance to do so because, when faced with an unavoidable obligation to make a payment at a certain level, it may prefer to make that payment to an ERISA plan. However, as *Travelers* makes clear, such influence is entirely permissible.

In *Travelers*, a New York statute required hospitals to collect surcharges from patients covered by commercial insurance companies, including those administering ERISA plans, but not from patients covered by Blue Cross/Blue Shield plans. The difference in treatment was justified on the ground that "the Blues pay the hospitals promptly and efficiently and, more importantly, provide coverage for many subscribers whom the commercial insurers would reject as unacceptable risks." *Travelers*, 514 U.S. at 658. The Court recognized that the surcharge might influence "choices made by insurance buyers, including ERISA plans." *Id.* at 659. But such an influence was not fatal to the New York statute: "An indirect economic influence . . . does not bind plan administrators to any particular choice and thus function as a regulation of an ERISA plan itself[.] . . . Nor does the indi-

rect influence of the surcharges preclude uniform administrative practice[.]" *Id.* at 659-60.

In this case, the influence exerted by the Ordinance is even less direct than the influence in *Travelers*. In *Travelers*, the required surcharge on benefits provided under ERISA plans administered by commercial insurers inescapably changed the cost structure for those plans' health care benefits and thereby exerted economic pressure on the manner in which the plans would be administered. Here, by contrast, the Ordinance does not regulate benefits or charges for benefits provided by ERISA plans. Its only influence is on the employer who, because of the Ordinance, may choose to make its required health care expenditures to an ERISA plan rather than to the City.

Further, the Ordinance does not "bind[ERISA plan administrators to a particular choice of rules" for determining plan eligibility or entitlement to particular benefits. *See Egelhoff*, 532 U.S. at 147. Employers may "structur[e] their employee benefit plans" in a variety of ways and need not "pay employees specific benefits." *See Shaw*, 463 U.S. at 97. The Ordinance affects employers, but it "leave[s] plan administrators right where they would be in any case." *Travelers Ins. Co.*, 514 U.S. at 662. *See also WSB Elec., Inc. v. Curry*, 88 F.3d 788, 793 (9th Cir. 1996) ("The scheme does not force employers to provide any particular employee benefits or plans, to alter their existing plans, or to even provide ERISA plans or employee benefits at all."); *Keystone Chapter, Associated Builders & Contractors, Inc. v. Foley*, 37 F.3d 945, 960 (3d Cir. 1994) ("Where a legal requirement may be easily satisfied through means unconnected to ERISA plans, and only relates to ERISA plans at the election of an employer, it affects

employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan.") (some internal quotation marks omitted).

Finally, the Ordinance does not impose on plan administrators any "administrative [or] financial burden of complying with conflicting directives" relating to benefits law. *Ingersoll-Rand Co.*, 498 U.S. at 142. The Ordinance does impose an administrative burden on covered employers, for they must keep track of their obligations to make expenditures on behalf of covered employees and must maintain records to show that they have complied with the Ordinance. But these burdens exist whether or not a covered employer has an ERISA plan. Thus, they are burdens on the employer rather than on an ERISA plan. *See WSB Elec., Inc.*, 88 F.3d at 795 (rejecting the argument that a law "is preempted because it imposes additional administrative burdens regarding benefits contributions on *the employer*," where it did "not impose any additional burden on ERISA plans or require the employer to take any action with regard to those plans") (emphasis in original).

b. "Reference to" a Plan

To determine whether a law has a forbidden "reference to" ERISA plans, we ask whether (1) the law "acts immediately and exclusively upon ERISA plans," or (2) "the existence of ERISA plans is essential to the law's operation." *Dillingham*, 519 U.S. at 325.

Mackey v. Lanier Collection Agency & Service, Inc., 486 U.S. 825 (1988), demonstrates that the Ordinance is not preempted under the first part of the inquiry. In *Mackey*, the Court held that ERISA

preempted a provision of a state garnishment statute that specifically exempted ERISA benefits from the operation of the statute, even while the statute subjected other assets to garnishment. *Id.* at 828-29. The Court noted that the provision "solely applie[d] to" ERISA plans, and "single[d] out ERISA . . . plans for different treatment under state" law. *Id.* at 829-30. At the same time, however, the Court upheld those aspects of the state statute that did "not single out or specially mention ERISA plans of any kind," even though they would potentially subject ERISA plans to "substantial administrative burdens and costs." *Id.* at 831. In *Dillingham*, the Court characterized the preempted statute in *Mackey* as "act[ing] immediately and exclusively upon ERISA plans." *Dillingham*, 519 U.S. at 325. Here, unlike the preempted statute in *Mackey*, the Ordinance does not act on ERISA plans at all, let alone immediately and exclusively.

Two cases demonstrate that the Ordinance is not preempted under the second part of the inquiry. The first is *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 140 (1990), in which the Court held that ERISA preempted a state law that "ma[de] specific reference to, and indeed [wa]s premised on, the existence of an ERISA plan. In order for a party to bring a claim under the challenged law, "a plaintiff must plead, and the court must find, that an ERISA plan exists." *Id.* Here, by contrast, the Ordinance can have its full force and effect even if no employer in the City has an ERISA plan. Covered employers without ERISA plans can discharge their obligation under the Ordinance simply by making their required health care expenditures to the City.

The second case is *District of Columbia v. Greater Washington Board of Trade ("Greater Washington")*, 506 U.S. 125 (1992). A local ordinance required employers to provide workers' compensation benefits "measured by reference to 'the existing health insurance coverage' provided by the employer," and required that the coverage 'be at the same benefit level' as the existing coverage. *Id.* at 130. The Court held that the ordinance contained an impermissible "reference to" an ERISA plan because its requirement was measured by reference to the level of benefits provided by the employer's ERISA plan.

The district court in this case relied on the Court's opinion in *Greater Washington* in holding that the Ordinance is preempted. The district court wrote, "By mandating employee health benefit structures and administration, [the Ordinance's health care expenditure] requirements interfere with preserving employer autonomy over whether and how to provide employee health coverage, and ensuring uniform national regulation of such coverage." *Golden Gate Rest. Ass'n*, 535 F.Supp. 2d at 975. Further, according to the district court, "The provisions [of the Ordinance] require private employers to meet a certain level of benefits; and those benefits are the type regularly provided by employer ERISA plans." *Id.* at 976. The district court concluded, "This Court finds that [the structure of the Ordinance] is akin to the statute the Supreme Court found preempted in *District of Columbia v. Greater Washington Board of Trade* which required the employer to provide the same amount of health care coverage for workers eligible for workers compensation." *Id.* at 978.

There is a critical distinction between the ordinance in *Greater Washington* and the Ordinance in

this case. Under the ordinance in *Greater Washington*, obligations were measured by reference to the level of *benefits* provided by the ERISA plan to the employee. Under the Ordinance in our case, by contrast, an employer's obligations to the City are measured by reference to the *payments* provided by the employer to an ERISA plan or to another entity specified in the Ordinance, including the City. The employer calculates its required payments based on the hours worked by its employees, rather than on the value or nature of the benefits available to ERISA plan participants. Thus, unlike the ordinance in *Greater Washington*, the Ordinance in this case is not determined, in the words of § 514(a), by "reference to" an ERISA plan.

The Ordinance in this case is conceptually similar to a California prevailing wage statute challenged in *WSB Electric, Inc. v. Curry*, 88 F.3d 788 (9th Cir. 1996). In that case, the California statute required an employer to pay the prevailing wage, consisting of a combination of cash and benefits. To calculate the total wage, the employer added the hourly cash wage to its hourly contribution to the employee's benefit package. However, the statute required that a certain minimum amount be paid as a cash wage, a requirement which had the effect of putting a cap on the amount the employer could be credited for payments made to fund a benefit package. The employer was free to contribute more than the cap amount to a benefit package, but any amount above the cap was not counted toward satisfaction of the prevailing wage requirement. *Id.* at 790-91.

The plaintiffs in *WSB Electric* contended that the California statute was preempted by ERISA, pointing out that some of the employers were making payments

to ERISA plans, and that benefits were paid out to the employees under these plans. *Id.* at 792-93. We held, however, that the statute was not preempted. We wrote:

> At most, this scheme provides examples of the types of employer contributions to benefits that are included in the wage calculation. The scheme does not force employers to provide any particular employee benefits or plans, to alter their existing plans, or to even provide ERISA plans or employee benefits at all. These provisions are enforced regardless of whether the individual employer provides benefits through ERISA plans, or whether the benefit contributions in a given locality are paid to ERISA plans.

Id. at 793-94 (citation and footnote omitted). Here, as in *WSB Electric*, employers need not have any ERISA plan at all; and if they do have such a plan, they need not make any changes to it. Where a law is fully functional even in the absence of a single ERISA plan, as it was in *WSB Electric* and as it is in this case, it does not make an impermissible reference to ERISA plans. *Cf. Travelers Ins. Co.*, 514 U.S. at 656 ("The surcharges are imposed upon patients and HMO's, regardless of whether the commercial coverage or membership, respectively, is ultimately secured by an ERISA plan, private purchase, or otherwise, with the consequence that the surcharge statutes cannot be said to make 'reference to' ERISA plans in any manner.").

C. *Retail Industry Leaders Association v. Fielder*

Finally, the Association contends that the Ordinance is preempted under the analysis set forth in *Retail Industry Leaders Association v. Fielder*, 475

F.3d 180, 183 (4th Cir. 2007). The Association contends that we will create a circuit split if we uphold the Ordinance. We disagree. We see no inconsistency between the Fourth Circuit's holding in *Fielder* and our holding in this case.

We neither adopt nor reject the analysis of the Fourth Circuit in *Fielder*. The panel majority in that case held a Maryland law preempted over a forceful dissent. *Id.* at 201-04 (Michael, J., dissenting); *see also* Catherine L. Fisk & Michael M. Oswalt, *Preemption and Civic Democracy in the Battle over Wal-Mart*, 92 Minn. L. Rev. 1502, 1514-20 (2008). For purposes of argument, however, we assume that the panel majority in *Fielder* was correct. But even under the reasoning of the panel majority, San Francisco's Ordinance is valid.

The Maryland law at issue in *Fielder* required "employers with 10,000 or more Maryland employees to spend at least 8% of their total payrolls on employees' health insurance costs or pay the amount their spending falls short to the State of Maryland." *Fielder*, 475 F.3d at 183 (majority opinion). The Maryland law gave nothing in return—either to an employer or its employees—for the employer's payment to the State.

Wal-Mart was the only employer in Maryland affected by the law's minimum spending requirements. On the face of the law, Wal-Mart appeared to have two options. To reach the required spending level of 8%, it could either increase contributions to its own ERISA plan, or it could pay money to the State of Maryland. But the Fourth Circuit concluded that, in practical fact, Wal-Mart had no choice. The court wrote that Wal-Mart had "noted by way of affidavit [that] it would not pay the State a sum of

money that it could instead spend on its employees' healthcare." *Id.* at 193. The Fourth Circuit wrote in *Fielder*:

> This would be the decision of any reasonable employer. Healthcare benefits are a part of the total package of employee compensation an employer gives in consideration for an employee's services. An employer would gain from increasing the compensation it offers employees through improved retention and performance of present employees and the ability to attract more and better new employees. In contrast, an employer would gain nothing in consideration of paying a greater sum of money to the State. Indeed, it might suffer from lower employee morale and increased public condemnation.
>
> In effect, the only rational choice employers have under the [Maryland law] is to structure their ERISA healthcare benefit plans so as to meet the minimum spending threshold.

Id. The court wrote further: "[T]he amount that the [Maryland law] prescribes for payment to the State is actually a fee or a penalty that gives the employer an irresistible incentive to provide its employees with a greater level of health benefits." *Id.* at 194. Therefore, the court concluded, "the choices given in the [Maryland law] . . . are not meaningful alternatives by which an employer can increase its healthcare spending to comply with the [law] without affecting its ERISA plans." *Id.* at 196.

In stark contrast to the Maryland law in *Fielder*, the City-payment option under the San Francisco Ordinance offers employers a meaningful alternative that allows them to preserve the existing structure of

their ERISA plans. If an employer elects to pay the City, that employer's employees are eligible for free or discounted enrollment in the HAP, or for medical reimbursement accounts. In contrast to the Maryland law, the San Francisco Ordinance provides tangible benefits to employees when their employers choose to pay the City rather than to establish or alter ERISA plans. In its motion for summary judgment, the Association provided no evidence to demonstrate that San Francisco employers are, in practical fact, compelled to alter or establish ERISA plans rather than to make payments to the City.[5]

Because the City-payment option offers San Francisco employers a realistic alternative to creating or altering ERISA plans, the Ordinance does not "effectively mandate[ ] that employers structure their employee healthcare plans to provide a certain level of benefits." *See Fielder*, 475 F.3d at 193. In the view of the *Fielder* court, Maryland legislators intended to "force Wal-Mart to increase its spending on healthcare benefits rather than to pay monies to the State." *Id.* at 185. Unlike the Maryland law, the San Francisco Ordinance provides employers with a legitimate alternative to establishing or altering ERISA plans. *See Travelers Ins. Co.*, 514 U.S. at 664 (stating that if

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[5] We do not rely on the following to support our decision, but we note that San Francisco has reported that as of May 1, 2008, more than seven hundred San Francisco employers have elected to comply with the Ordinance by making their health care expenditures directly to the City. Office of the Mayor, City & County of S.F., Mayor Newsom Announces Hundreds of Employers Signing Up for Healthy San Francisco Program, May 1, 2008, http://www.healthysanfrancisco.org/files/PDF/HSF Release 5.1.2008.pdf. This document indicates that 734 employers had elected to make payments to the City on behalf of 12,900 employees. *Id.*

the New York surcharges had been "an exorbitant tax," they might leave ERISA plan purchasers "with a Hobson's choice," thereby amounting to an impermissible substantive mandate, but concluding that there was no evidence that the surcharges are so prohibitive as to force all health insurance consumers to contract with the Blues"). We therefore conclude that the San Francisco Ordinance does not compel covered employers to establish or to alter ERISA plans. *Cf. Fielder*, 475 F.3d at 193.

Conclusion

There may be better ways to provide health care than to require employers in the City of San Francisco to foot the bill. But our task is a narrow one, and it is beyond our province to evaluate the wisdom of the Ordinance now before us. We are asked only to decide whether § 514(a) of ERISA preempts the employer spending requirements of the Ordinance. We hold that it does not. The spending requirements do not establish an ERISA plan; nor do they have an impermissible connection with employers' ERISA plans, or make an impermissible reference to such plans.

We therefore REVERSE the judgment of the district court and REMAND with instructions to enter summary judgment in favor of the City and Intervenors.

APPENDIX B

FOR PUBLICATION

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

No. 07-17370
D.C. No. CV-06-06997-JSW

GOLDEN GATE RESTAURANT, ASSOCIATION,
an incorporated non-profit trade association,
Plaintiff-Appellee,

v.

CITY AND COUNTY OF SAN FRANCISCO,
Defendant,

SAN FRANCISCO CENTRAL LABOR COUNCIL; SERVICE EMPLOYEES INTERNATIONAL UNION, HEALTHCARE WORKERS-WEST; SERVICE EMPLOYEES INTERNATIONAL UNION, LOCAL 1021; UNITE HERE LOCAL 2,
Defendant-intervenors-Appellants.

No. 07-17370
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GOLDEN GATE RESTAURANT, ASSOCIATION, an incorporated non-profit trade association,
Plaintiff-Appellee,

v.

CITY AND COUNTY OF SAN FRANCISCO,
Defendant,

SAN FRANCISCO CENTRAL LABOR COUNCIL; SERVICE EMPLOYEES INTERNATIONAL UNION, HEALTHCARE WORKERS-WEST; SERVICE EMPLOYEES INTERNATIONAL UNION, LOCAL 1021; UNITE HERE LOCAL 2,
Defendant-intervenors-Appellants.

Filed March 9, 2009

ORDER DENYING PETITION FOR REHEARING EN BANC

ORDER

Before: Alfred T. Goodwin, Stephen Reinhardt, and William A. Fletcher, Circuit Judges.

Order; Concurrence by Judge W. Fletcher; Dissent by Judge Milan D. Smith, Jr.

Judge Reinhardt and Judge Fletcher voted to deny the petition for rehearing en banc, and Judge Goodwin so recommended.

A judge of the court called for a vote on the petition for rehearing en banc. A vote was taken, and a majority of the active judges of the court failed to vote for en banc rehearing. Fed. R. App. P. 35(f). Judge Berzon was recused.

The petition for rehearing en banc, filed October 22, 2008, is DENIED.

W. FLETCHER, Circuit Judge, concurring in the denial of rehearing en banc:

A majority of the active judges of our court declined to vote for rehearing of this case en banc. I concur in the court's decision not to go en banc. I write to respond to the dissent from that decision.

The question is whether the San Francisco Health Care Security Ordinance ("the Ordinance") is pre-empted by ERISA. We describe the Ordinance in detail in our opinion. *See Golden Gate Restaurant Ass 'n v. City and County of San Francisco*, 546 F.3d 639, 643-47 (9th Cir. 2008). In brief, the Ordinance requires San Francisco employers to pay to the City of San Francisco what amounts to a tax. The tax is either $1.17 or $1.76 per hour per employee, depending on the profit or non-profit status of the employer and the number of employees. No employer is required by the Ordinance either to establish a new ERISA health care plan or to modify an existing ERISA health care plan. An employer may fully satisfy its obligation under the Ordinance by paying the tax to the City.

The Ordinance requires that San Francisco use the employers' payments to help support a City-administered program that provides health care to low- and moderate-income residents of San Francisco. The program is called the Health Access Program ("the HAP"). The employers' payments comprise only part of the support for the HAP. Some of those receiving health care under the HAP are employees of covered employers, but most are not. The Ordinance gives a covered employer a dollar-for-dollar credit for any amount paid by that employer for health care for its employees. That credited amount may be—but need not be—paid to an ERISA health care plan. The only

requirement in order to receive the credit is that the payment be for some form of health care. The benefits obtained by an employer's health care payments (as distinct from the amount paid for those benefits) are irrelevant to the calculation of the credit given to the employer.

The dissent makes several contentions. I disagree with all of them.

First, the dissent contends that our decision creates a circuit conflict with *Retail Industry Leaders Ass'n v. Fielder*, 475 F.3d 180 (4th Cir. 2007). At issue in *Fielder* was ERISA preemption of a Maryland law that required "employers with 10,000 or more Maryland employees to spend at least 8% of their total payrolls on employees' health insurance costs or pay the amount their spending falls short to the State of Maryland." *Id.* at 183. The only employer covered by the Maryland law was Wal-Mart. The Maryland law gave nothing in return—either to the Wal-Mart or its employees—for Wal-Mart's payment to the State.

Despite what appeared on the face of the Maryland law to be a choice between increasing ERISA health care coverage and paying money to the State, the Fourth Circuit held that the law impermissibly "related to" an ERISA plan. In the view of the court, there was no real choice. Instead, the inevitable effect of the law was to require Wal-Mart to increase its ERISA coverage of its employees. The court wrote:

> This would be the decision of any reasonable employer. Healthcare benefits are a part of the total package of employee compensation an employer gives in consideration for an employee's services. An employer would gain from increas-

> ing the compensation it offers employees through improved retention and performance of present employees and the ability to attract more and better new employees. In contrast, an employer would gain nothing in consideration of paying a greater sum of money to the State. Indeed, it might suffer from lower employee morale and increased public condemnation.
>
> *In effect, the only rational choice employers have under the [Maryland law] is to structure their ERISA healthcare benefit plans so as to meet the minimum spending threshold.*

Id. at 193 (emphasis added).

The Maryland law contrasts sharply with the San Francisco Ordinance. Under the Ordinance, an employer gains an advantage from its payments to the City, because employees of covered employers are entitled to obtain health care benefits from the HAP at reduced rates. Far from imposing a de facto obligation on an employer to establish or alter an ERISA plan, the Ordinance offers an employer a meaningful choice. As of May 1, 2008, more than seven hundred San Francisco employers had elected to pay money to the City rather than to alter their other health care expenditures. *Golden Gate*, 546 F.3d at 660 n.5.

The dissent nonetheless contends that our decision conflicts with *Fielder*. It contends, "Covered employers under San Francisco's Ordinance must coordinate their non-ERISA payments with their ERISA plans in the very manner the *Fielder* court deemed impermissible." Dissent at 2828. In support, the dissent quotes the first and last sentences from a passage

from *Fielder* but omits the intervening three sentences. The full passage is as follows:

> If Wal-Mart were to attempt to utilize non-ERISA health spending options to satisfy the [Maryland law], it would need to coordinate those spending efforts with its existing ERISA plans. For example, an individual would be eligible to establish a Health Savings Account only if he is enrolled in a high deductible health plan. In order for Wal-Mart to make widespread contributions to Health Savings Accounts, *it would have to alter its package of ERISA health insurance plans* to encourage its employees to enroll in one of its high deductible health plans. From the employer's perspective, the categories of ERISA and non-ERISA healthcare spending would not be isolated, unrelated costs. Decisions regarding one would affect the other and thereby violate ERISA's preemption provision.

Fielder, 475 F.3d at 196-97 (emphasis added) (citation omitted).

The omitted sentences make clear the difference between the Maryland law and the San Francisco Ordinance. If Wal-Mart chose to use non-ERISA spending options under the Maryland law, "it would have to alter its package of ERISA health insurance plans." *Id.* That is, Wal-Mart's use of the non-ERISA spending option would necessarily produce a change in its ERISA plans. This is not true under the San Francisco Ordinance. An employer's payment of the de facto tax to the City does not produce any change in any ERISA plan.

Second, the dissent contends that our decision conflicts with two Supreme Court decisions, *Egelhoff*

v. Egelhoff, 532 U.S. 141 (2001), and *District of Columbia v. Greater Washington Board of Trade*, 506 U.S. 125 (1992).

In *Egelhoff* the challenged state statute required ERISA plan administrators to follow state law in designating plan beneficiaries. The Court held the statute preempted because it "binds ERISA plan administrators to a particular choice of rules for determining beneficiary status." *Egelhoff*, 532 U.S. at 147. The Court wrote, "Plan administrators must either follow [the State's] beneficiary designation scheme or alter the terms of their plan so as to indicate that they will not follow it." *Id.* at 150. Because the statute in *Egelhoff* required a change in an ERISA plan under either choice, it was preempted. By contrast, the San Francisco Ordinance does not require any change to any ERISA plan.

In *Greater Washington*, a Washington, D.C. ordinance required employers to provide workers' compensation benefits to their employees. The level of required benefits was "measured by reference to the existing health insurance coverage provided by the employer." *Greater Washington*, 506 U.S. at 130. The Court held that the requirement that benefits be determined by reference to benefits provided in ERISA plans was an impermissible reference to an ERISA plan. By contrast, the San Francisco Ordinance requires employers to provide money to the City (rather than benefits to the employee), and determines the level of required payment by reference to hours worked by an employee (rather than by reference to benefits provided under an ERISA plan). An employer's required payment to the City may be reduced or eliminated if the employer makes payments to an employee's ERISA plan or to another

healthcare-providing entity; but the amount of the reduction is determined by reference to the amount of money paid.

Finally, the dissent contends that ERISA responds to the "need for nationally uniform plan administration" and a "uniform regulatory system." Dissent at 2832. The purpose of ERISA is not to require national uniformity in the provision of health care. Rather, its purpose is to "ensure[ ] that the administrative practices of a benefit plan will be governed by only a single set of regulations." *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 11 (1987). Nothing in the Ordinance requires the employer to establish an ERISA plan or to alter an existing ERISA plan, and nothing in the Ordinance interferes in any way with the uniformity of ERISA regulations.

M. SMITH, Circuit Judge, with whom KOZINSKI, Chief Judge, and O'SCANNLAIN, KLEINFELD, TALLMAN, BYBEE, CALLAHAN, and BEA, Circuit Judges, join dissenting from the denial of rehearing en banc:

I respectfully dissent from our court's denial of rehearing this case en banc. Our decision in this case creates a circuit split with the Fourth Circuit Court of Appeals, renders meaningless the tests the Supreme Court set out in *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983), conflicts with other Supreme Court cases establishing ERISA[1] preemption guidelines, and, most importantly, flouts the mandate of national uniformity in the area of employer-provided healthcare that underlies the enactment of ERISA. Our decision allows San Francisco to create an ordinance that effectively requires "ERISA administrators to master the relevant laws of 50 States"—which in turn "undermine[s] the congressional goal of 'minimiz[ing] the administrative and financial burden[s]' on plan administrators—burdens ultimately born by the beneficiaries." *Egelhoff v. Egelhoff*, 532 U.S. 141, 149-50 (2001).

The panel opinion creates "'a road map for state and local governments'"[2] seeking to regulate employee health plans despite ERISA's preemptive mandate. In my view, if our decision in this case remains good law, similar laws will become commonplace, and the congressional goal of national uniformity in the area of employer-provided healthcare will

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[1] Employee Retirement Income Security Act of 1974 (ERISA).

[2] Jason Dearen, Federal Court Upholds San Francisco Healthcare Program, L.A. Times, Sept. 30, 2008 (quoting City Attorney Dennis Herrera).

be thoroughly undermined, with significant adverse consequences to employers and employees alike.

I

The San Francisco Health Care Security Ordinance (Ordinance, or San Francisco Ordinance) requires that covered employers[3] within San Francisco make minimum "expenditures" to their own programs for their employees' health care *or* instead make contributions in the required amounts to the city. These alternative contributions go to finance either San Francisco's Health Access Program (HAP) or health "reimbursement accounts." The HAP serves uninsured San Francisco residents, while the "reimbursement accounts" are assigned to employees of the covered employers. For large businesses, the required employer's rate in 2008 for health care expenditures is $1.76 for each hour worked by a covered employee. The Ordinance also imposes extensive record keeping and reporting requirements on San Francisco employers, and creates penalties for employers who fail to comply with these requirements.[4]

Golden Gate Restaurant Association (GGRA) filed suit on November 8, 2006 against the City of San Francisco, in the Northern District of California, asking the district court to find that ERISA preempts

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[3] A covered employer is a for-profit employer engaged in business in San Francisco for whom at least twenty persons work, or a nonprofit employer in San Francisco for whom at least fifty persons work. San Francisco Health Care Security Ordinance (HSAO), §§ 14.1(b)(3), 14.1(b)(4) and 14.1(b)(15).

[4] The Ordinance requires covered employers to keep "accurate records of health care expenditures, required health care expenditures, and proof of such expenditures made each quarter each year." HSAO § 14. l(b)(i).

the employer spending requirements of the Ordinance, and seeking a permanent injunction against enforcement of those provisions. The parties filed cross-motions for summary judgment.

On December 27, 2007, Judge Jeffrey S. White entered judgment for GGRA, finding that ERISA Section 514(a) preempts the Ordinance. *Golden Gate Rest. Ass'n v. City & County of San Fran.*, 535 F. Supp. 2d 968 (N.D. Cal. 2007). Section 514(a) states that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." To determine whether the Ordinance "related to" an employee benefit plan, Judge White applied the two tests articulated by the Supreme Court in *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983). These tests examine (1) whether a law has a "connection with" employers' ERISA-regulated plans, or (2) whether such law makes "reference to" such employer-sponsored plans. If either test is met, the ordinance is preempted under Section 514(a). Judge White found the San Francisco Ordinance preempted under both tests. 535 F. Supp. 2d at 975.

Applying the first test, Judge White found that the Ordinance has an impermissible connection with affected employer ERISA plans in four ways: (1) "the Ordinance affects plan administration, a core area of ERISA concern"; (2) the enforcement provisions impermissibly "impose on employers specific record keeping, inspection and other administrative burdens" which are "ongoing and directly affect" the scheme of health care benefits; (3) "the Ordinance directly and indirectly affects the structure and administration of ERISA plans"; and (4) the Ordinance "has a prohibited connection with ERISA plans because it interferes with nationally uniform plan

administration." *Id.* at 975-77. Although the district court acknowledged that required payments under the Ordinance could be made directly to a public entitlement program, effectively bypassing employer ERISA plans, "[t]he undeniable fact is that the vast majority of any employer's healthcare spending occurs through ERISA plans. Thus, the primary subjects of the [expenditure requirements] are ERISA plans, and any attempt to comply with the statute would have direct effects on the employer's ERISA plans." *Id.* at 976 (quoting *Retail Indus. Leaders Ass'n v. Fielder*, 475 F.3d 180, 196 (4th Cir, 2007)).

Applying the second Shaw test, Judge White found that the Ordinance impermissibly makes reference to employers' ERISA plans by defining "health care expenditure" in such a way that compliance can only be determined with reference to the employer's ERISA-regulated health plan.[5] I believe Judge White's well reasoned opinion should have been upheld by our court.

II

Our merits panel disagreed with Judge White, and determined that the Ordinance does not "relate to" ERISA plans. The panel reasoned that because the Ordinance does not require an employer to adopt an ERISA plan or to provide benefits though an ERISA plan (as a covered employer can discharge its expenditure obligations by making payments to the city), the Ordinance sidesteps Section 514(a) preemption. The panel also indicated that the Ordinance was

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[5] Judge White did not, as the plaintiff and many of the amici urged, find that payments to the city under the Ordinance created an ERISA plan.

not preempted because it regulated employer payments instead of employee benefits.

A

In so holding, the panel's decision conflicts with a recent case from the Fourth Circuit Court of Appeals. In 2007, the Fourth Circuit struck down a similar state statute in *Fielder*, 475 F.3d at 183.[6] In that case, the ordinance at issue required covered employers to spend at least 8% of their payroll costs on health insurance, or else to pay a like sum of money to the state of Maryland. *Fielder* held that ERISA Section 514(a) preempted the Maryland statute because the statute forced employers either to make minimum health care contributions to ERISA plans for its employees or to make contributions to Maryland's Health Care Fund. The Fourth Circuit recognized that "categories of ERISA and non-ERISA healthcare spending [are not] isolated, unrelated costs." *Id.* at 197. Further, the court reasoned that "fair share laws," such as the Maryland law, were impermissibly connected with ERISA plans because they "would disrupt employers' uniform administration of employee benefit plans on a nationwide basis." *Id.* at 194.

In *Golden Gate*, the panel distinguishes *Fielder* by noting that the Maryland law created no "meaningful alternative" for the employer other than increasing their current health plans. The alternative, which the panel dismissed, was simply a tax on the employers, which was not earmarked towards their employees'

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[6] In addition, in *Retail Indus. Leaders Ass'n v. Suffolk County*, 497 F. Supp. 2d 403 (E.D.N.Y. 2007), the Eastern District of New York held that ERISA preempts a similar Suffolk County ordinance.

insurance, but rather towards general entitlement funds. Our panel implies that in the San Francisco Ordinance, the municipally funded health alternative is somehow more "meaningful." This meaning ostensibly comes from the fact that employers are still contributing to their specific employees health care, albeit through the administration of the city.

Such a distinction conflicts with the reasoning of *Fielder*. The *Fielder* court explained that even were there a more "meaningful avenue" by which the employer could make nonERISA healthcare payments, the Maryland statute was still impermissibly connected to ERISA plans. 475 F.3d at 196-97 ("If [the employer] were to attempt to utilize non-ERISA health spending options to [comply with the statute], it would need to coordinate those spending efforts with its existing ERISA plans. . . . Decisions regarding one would affect the other and thereby violate ERISA's preemption provision."). Covered employers under San Francisco's Ordinance must coordinate their non-ERISA payments with their ERISA plans in the very manner the *Fielder* court deemed impermissible. When determining how much, if any, payment they have to make to the city to be in compliance, they necessarily need to evaluate and coordinate with their existing ERISA plans. A currently non-complying employer in San Francisco has the same choice as a non-complying employer in Maryland: Make a payment to the government or change its current ERISA plan. Where the employer's payment goes after the employer makes its choice does not change the fundamental nature of the payment from a penalty to a "meaningful avenue."

The holdings of *Fielder* and *Golden Gate* stand in clear opposition, and create a circuit split on the issue

of whether ERISA preempts "fair share" or "play-or-pay" ordinances.

B

Further, the *Golden Gate* panel opinion disregards important case law setting forth ERISA preemption principles. ERISA preemption's "goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government . . . , [and to prevent] the potential for conflict in substantive law . . . requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction." *NY. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 656-57 (1995) (quoting *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990)). The burden of conflicting obligations on employers operating in multiple jurisdictions "is exactly the burden that ERISA seeks to eliminate." *Egelhoff*. 532 U.S. at 151. "Requiring ERISA administrators to master the relevant laws of 50 States . . . would undermine the congressional goal of 'minimiz[ing] the administrative and financial burden[s]' on plan administrators—burdens ultimately born by the beneficiaries." *Id.* at 149-50 (quoting *Ingersoll-Rand Co.*, 498 U.S. at 142). The opinion in *Golden Gate* conflicts with these ERISA preemption principles.

In *Egelhoff*, the Court dismissed the argument that states can avoid preemption by offering employers a theoretical means to avoid changing their current ERISA plans. 532 U.S. at 147-48. Although employers were able to "opt out of the state law requirement, the law had "a connection with" the ERISA plan and was thus preempted. *Id.* at 150. The court held that "[t]he statute is not any less of a regulation of the

terms of ERISA plans simply because there are two ways of complying with it." *Id.* The San Francisco Ordinance at issue here is similarly connected, as it structures employers' choices with respect to their existing ERISA plans. Noncomplying San Francisco employers have a choice: either increase or maintain their health care expenditures under their own plans, or, pay enough to the city to satisfy that mandated minimum. Per *Egelhoff* a law like the San Francisco ordinance is ERISA-preempted because it frames employers' choices in this fashion.

Further, allowing San Francisco to pose such a choice would strike at the heart of ERISA because the plan administrators would have to account for potential opt-out provisions in all 50 states. *Id.* at 151. *Egelhoff* explained this burden:

> It is not enough for plan administrators to opt out of this particular statute. Instead, they must maintain a familiarity with the laws of all 50 States so that they can update their plans as necessary to satisfy the opt-out requirements of other, similar statutes. They also must be attentive to changes in the interpretations of those statutes by state courts. This "tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction" is exactly the burden ERISA seeks to eliminate.

Id. (quoting *Indersoll-Rand*, 498 U.S. at 142). The Ordinance here places employers in a similar situation. As the Secretary of Labor observes, while the "administrative burden imposed by a single law may be tolerable, the cumulative burden could be staggering and runs directly counter to ERISA's goal of encouraging employers, who may operate nationally, voluntarily to provide uniform employee benefits

under the legal framework provided by a federal scheme with intentionally broad preemptive force." Secretary's Amicus Brief, at 15.

In addition, the *Golden Gate* opinion conflicts with *District of Columbia v. Greater Washington Board of Trade*, 506 U.S. 125 (1992). In that case, a D.C. ordinance required employers to provide the same medical coverage to injured employees as to non-injured, active employees. The Supreme Court struck down the ordinance, explaining that the statute impermissibly referred to an ERISA plan. *Id.* at 130. This was so even though D.C. employers did not need to amend their ERISA plans to comply with the ordinance; they could provide benefits for injured employees through a separate or non-ERISA plan. The Court found that the statute was preempted, however, because the benefits had to be equal, thereby requiring a comparison to the ERISA plan. Similarly, in *Golden Gate*, although covered employers may not need to amend their ERISA plans under the Ordinance, they can only determine their compliance by using their current ERISA plans as a reference.

The *Golden Gate* opinion attempted to distinguish this case by claiming that a "critical distinction" existed because "[u]nder the ordinance in *Greater Washington*, obligations were measured by reference to the level of *benefits* provided by the ERISA plan to the employee. Under the Ordinance in our case . . . [obligations] are measured by reference to the *payments* provided by the employer to an ERISA plan or to another entity." 546 F.3d at 658. Thus, the panel implies that the D.C. statute would have survived had the statute required covered employers to spend the same amount for injured and non-injured em-

ployees instead of requiring the benefits be equal. This distinction has no basis in the text of *Greater Washington* and greatly revises ERISA preemption case law.

Finally, and most importantly, I dissent because this case concerns an issue of exceptional national importance, i.e., national uniformity in the area of employer-provided healthcare. The Fourth Circuit in *Fielder* and the district court here both considered the need for nationally uniform plan administration to be the central concern of the Supreme Court's ERISA preemption case law. The diverse interests of the amicus groups who wrote in support of both positions indicates the level of far-reaching national importance the *Golden Gate* decision has for many groups across the United States.[7]

At the time of ERISA's enactment, a coalition reflecting employer and labor interests sought the establishment of a uniform regulatory system for retirement and welfare benefit plans.[8] As amici the

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[7] The plaintiff-appellants had eight amicus briefs submitted in support of their position, by the United States Department of Labor, National Federation of Independent Business Legal Foundation, Retail Industry Leaders Association/ United States Chamber of Commerce, Human Resource Policy Association, Employers Group/California Chamber of Commerce, International Franchise Association/Society for Human Resource Management/National Association of Manufacturers, ERISA Industry Committee/National Business group on Health, and the American Benefits Council. The defendants-appellees had two amicus briefs submitted in support of their position, by the American Association of Retired People and the Attorney General of the State of California.

[8] Wooten, James A., "A Legislative and Political History of ERISA Preemption, Part 2." JOURNAL OF PENSION BENEFITS, Vol. 14, No. 3, p. 10, Spring 2007; Buffalo Legal Studies Re-

ERISA Industry Committee and the National Business Group on Health note in their brief, the legislators who helped push ERISA through Congress were focused on a broad preemption provision. Senator Javits remarked that "the emergence of a comprehensive and pervasive Federal interest and the interests of uniformity with respect to interstate plans required . . . the displacement of State action in the field of private employee benefits programs." 129 Cong. Rec. 29942 (Aug. 22, 1974). Representative Dent remarked, "[w]ith the preemption of the field, we round out the protection afforded to participants by eliminating the threat of conflicting and inconsistent State and local regulation." *Id.* Finally, Senator Williams added:

> [T]he substantive and enforcement provisions of the conference substitute are intended to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans. This principle is intended to apply in the broadest sense to all actions of State or local governments, or any instrumentality thereof, which have the force or effect of law.

Id. The *Golden Gate* panel opinion ignores ERISA's preemption goals and instead focuses on ERISA's objective of protecting against misuse of benefit plan funds. While misuse was undoubtedly a concern, it is clear from the cited language that preemption was central to ERISA's implementation.

The problems that the Ordinance poses to multi-jurisdictional employers are significant. Without un-

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search Paper No. 2007-018. Available at SSRN: http://ssrn.com/abstract=1023699.

iformity, multi-state employers cannot offer all of their similarly situated employees the same benefits, and creates no possibility of continuity in benefit programs. Our panel's decision essentially guarantees, for example, that employees of a national chain restaurant in Oakland will receive different benefits than similarly situated employees of the same restaurant just a few miles away in San Francisco. Uniformity is essential to ensuring that employees understand what benefits they are entitled to and how to obtain them. Covered employers in San Francisco must continuously monitor the City's spending targets, make quarterly calculations for health care expenditures, keep abreast of varying definitions for different employees, track eligibility waiting periods for each individual employee, and maintain the records keeping requirements of the Ordinance. While this may not be difficult on a small scale, if we consider the possibility of numerous cities, counties and states enacting similar laws, the burden this places on employers is potentially very great, thereby encouraging affected employers to drop their ERISA plans as a cost saving measure. If upheld, *Golden Gate* will undoubtedly serve as a roadmap in jurisdictions across the country on how to design and enact a labyrinth of laws requiring employer compliance on health care expenditures, thereby creating the very kind of health care expenditure balkanization ERISA was intended to avoid.

III

I dissent because I believe the San Francisco Ordinance is clearly preempted by ERISA Section 514(a). Contrary to the arguments made by Judge W. Fletcher in both the Concurrence and the original panel opinion, our decision here creates a circuit split

with the Fourth Circuit, undercuts the Supreme Court's ERISA preemption case law, and creates a roadmap for the enactment of numerous conflicting health care laws affecting national employers, the very situation Congress strove to avoid when it enacted ERISA.

APPENDIX C

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

Nos. 07-17370, 07-17372

GOLDEN GATE RESTAURANT ASSOCIATION,
Plaintiff-Appellee,

v.

CITY AND COUNTY OF SAN FRANCISCO,
Defendants-Appellants

and

SAN FRANCISCO CENTRAL LABOR COUNCIL, SERVICE EMPLOYEES INTERNATIONAL UNION LOCAL 1021, SEIU UNITED HEALTHCARE WORKERS-WEST, and UNITE-HERE! LOCAL 2,
Intervenors-Appellants.

On Appeal from the United States District Court
for the Northern District of California

BRIEF FOR THE SECRETARY OF LABOR
AS AMICUS CURIAE SUPPORTING
PETITION FOR REHEARING

Decided September 30, 2008

Panel Members W. Fletcher, Reinhardt, Goodwin

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STATEMENT PURSUANT TO RULES 29 AND 35 OF THE FEDERAL RULES OF APPELLATE PROCEDURE

Petitioner Golden Gate Restaurant Association seeks en banc reconsideration and reversal of the panel decision in this case holding that the employer health care spending requirements in San Francisco's Health Care Security Ordinance ("HCSO"), S.F. Cal. Admin. Code, Ch. 14 (2006 & 2007), are not preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001 *et seq.*, as amended. The Secretary of Labor, who has primary authority for enforcing and administering Title I of ERISA, 29 U.S.C. §§ 1002(13), 1136(b), filed an amicus brief and presented oral argument in support of preemption, and files this brief in support of the rehearing en banc.

Rehearing en banc is appropriate under Fed. R. App. P. 35(a)(2) and (b)(1)(B) because the extent to which ERISA permits state or local governments to require employers to pay for or provide medical benefits for their employees is a question of exceptional importance due to the significant, disruptive consequences of a ruling that undermines the federal ERISA scheme by exposing employers to the complexity of complying with a potential myriad of state and local laws similar but not identical to the HCSO. Rehearing en banc is also appropriate because the panel's decision conflicts with preemption principles applied by the Supreme Court, including in *Egelhoff v. Egelhoff*, 532 U.S. 141 (2001), and by the Fourth Circuit in *Retail Industry Leaders Ass'n v. Fielder*, 475 F.3d 180 (4th Cir. 2007). *See* Fed. R. App. P. 35(b)(1)(A).

The panel decision also threatens uniformity of this Court's decisions. *See* Fed. R. App. P. 35(a)(1). In concluding that the law's City-payment option does not create an ERISA plan, the panel failed to address *Qualls v. Blue Cross of Cal.*, 22 F.3d 839, 843 (9th Cir. 1994), which held that an employer establishes an ERISA plan when it makes payments to a third-party insurer-plan administrator, and incorrectly applied a heightened test for determining when a plan exists by improperly deeming *Scott v. Gulf Oil Corp.*, 754 F.2d 1499, 1503-04 (9th Cir. 1985), to be overruled. Moreover, the panel mischaracterized the Secretary's argument. The panel viewed the Secretary as arguing that the City-run program to which employers make payments is itself an ERISA plan. Panel Op. at 13,927, 13,935. The Secretary never made that argument. Instead, the Secretary argued that when an employer chooses that option, the employer establishes an ERISA plan in the same way that the employer's payment to an insurer established a plan under Qualls.

STATEMENT

This case arose after San Francisco enacted the HCSO to provide health care for uninsured residents. *See generally* Panel Op. at 13,916; Pet. for Reh'g at 1. The law establishes a City-run Health Access Program ("HAP," now called "Healthy San Francisco") for uninsured residents and by requiring covered employers to make specified health care expenditures on behalf of their employees for each hour paid to covered employees. Current rates are $1.76 per hour for large for-profit employers, and $1.17 per hour for medium-size for-profit employers and certain non-profit employers. *Id.* § 14.1(b)(8).

The HCSO defines "health care expenditure" to mean "any amount paid by a covered employer to its covered employees or to a third party on behalf of its covered employees for the purpose of providing health care services for covered employees or reimbursing the cost of such services for its covered employees." S.F. Admin. Code § 14.1(b)(7). That definition includes payments to entities that are indisputably ERISA plans. *See* 29 U.S.C. § 1002(1), (7) (ERISA welfare benefit plan includes any plan, fund, or program providing, among other things, medical benefits to participants (employees or former employees) and their beneficiaries); Panel Op. at 13,940 ("A covered employer may choose to adopt or to change an ERISA plan" to comply with the law). The definition also includes payments to the City-run HAP to be used on behalf of covered employees. S.F. Admin. Code § 14.1(b)(7).

Golden Gate challenged the HCSO as preempted by ERISA. The district court agreed with Golden Gate that ERISA preempts the health care spending requirements. *Golden Gate Restaurant Ass'n v. City and County of San Francisco*, 535 F. Supp. 2d 968 (N.D. Cal. 2007). In January 2008, the panel stayed the district court's decision. *Golden Gate Restaurant Ass'n v. City and County of San Francisco*, 512 F.3d 1112 (9th Cir. 2008).

The Secretary filed an amicus brief supporting Golden Gate. The Secretary argued that ERISA preempts the employer spending requirements for two independent reasons: it mandates employee benefit structures or their administration, and it interferes with uniform plan administration. Sec'y Amicus Br. 8-9. On the first point, the Secretary argued that all of the options for compliance require an employer to

create or alter an ERISA plan, including the City-payment option that the panel, in its stay decision, had assumed did not require the creation or alteration of an ERISA plan. *Id.* at 9. The Secretary explained that an employer must establish an ERISA plan to comply with the City-payment option, the same way an employer establishes a plan through, among other things, purchasing group insurance. *Id.* at 13-17 (discussing, among other cases, *Qualls*, 22 F.3d at 843). On the second point, the Secretary argued that panel's stay decision, which concluded that the HCSO imposes permissible administrative burdens on employers, was incompatible with controlling precedents, record evidence, the realities of employee benefit plan administration, and the Fourth Circuit *Fielder* decision. Sec'y Amicus Br. 23.

In its decision on the merits, the panel held that ERISA does not preempt the San Francisco law. Panel Op. at 13,916, 13,924-46. The panel did not dispute the Secretary's assertion that all of the non-City payment options require an employer to create or alter an ERISA plan. The panel also concluded that if the City-payment option creates an ERISA plan, the HCSO "almost certainly makes an impermissible 'reference to' an ERISA plan." Panel Op. at 13,927. The panel, however, rejected the argument that the City-payment option requires employers to establish ERISA plans because, in its view, the administrative burdens it imposes on employers are not enough to create a plan and those burdens do not require employer discretion or run the risk of mismanagement of funds or other abuses. *Id.* at 13,927-34. Addressing an argument not previously raised by the Secretary or Golden Gate, the panel also concluded that the HAP itself is not an ERISA plan but instead is a government entitlement program funded

in part by the employer payments but primarily by taxpayer dollars and available to low- and moderate-income San Francisco residents regardless of employment status, and, as such, is beyond the reach of ERISA preemption. *Id.* at 13,934-37.

The panel also rejected the argument that the HCSO impermissibly interferes with uniform plan administration. Panel Op. at 13,938. The panel concluded that San Francisco's law is consistent with ERISA's goal of promoting plan uniformity because, based on its analysis of the City-payment option, the HCSO does not require any employer to adopt or alter an ERISA plan or require any employer to provide specific benefits through an existing ERISA plan or the HAP. *Id.* at 13,940. The panel recognized that the law may "influence[]" an employer to choose to adopt or change an ERISA plan instead of making the required health care expenditures to the City, but concluded that such an "influence" is permissible because it does not bind ERISA plan administrators to a particular choice of benefits or rules for determining plan eligibility, *id.* at 13,94041, and because the administrative burden is on the employer and not on the plan. *Id.* at 13,942.

The panel further concluded that its decision is consistent with *Fielder*. In *Fielder*, the Fourth Circuit held that ERISA preempts a Maryland law that targeted WalMart by requiring employers with 10,000 or more Maryland employees to spend at least 8% of their total payrolls on employees' health insurance costs or pay the shortfall to the state Medicaid fund. *Fielder*, 475 F.3d at 183. The panel reasoned that its decision is consistent with *Fielder* because the San Francisco law, unlike the Maryland law,

gives employers a realistic way to comply other than by creating or altering ERISA plans. *Id.* at 13,948.

ARGUMENT

Rehearing en banc should be granted because this case raises a recurring issue of exceptional importance concerning the extent to which ERISA permits recent attempts by state or local governments to require employers to pay for or provide medical benefits for their employees. *See* Supp. Excerpts of Record 49-53 (National Conference of State Legislatures listing of 2006-2007 Fair Share Health Care Fund or "Pay or Play" Bills); Pet. for Reh'g En Banc 2. Until now, the two courts that have addressed such laws have concluded that ERISA preempts them. *See Fielder*, 475 F.3d at 193-97 (4th Cir. 2007); *Retail Indus. Leaders Ass'n v. Suffolk County*, 497 F. Supp. 2d 403, 416-18 (E.D.N.Y. 2007). As Golden Gate argues, Pet. for Reh'g En Banc 2-3, the panel's contrary decision opens the door to potentially inconsistent state and local regulation of employer-provided healthcare that cannot be reconciled with ERISA's preemption, in the interest of maintaining a nationally uniform scheme of applicable legal requirements, of state and local laws that mandate employee benefit structures or their administration or that interfere with uniform plan administration. The panel's decision also threatens intra-circuit uniformity on the nature of ERISA plans and conflicts with preemption principles recognized by the Supreme Court and the Fourth Circuit's decision in *Fielder*.

Introduction

ERISA regulates the provision of health benefits by private employers. An ERISA covered plan is simply an arrangement by which private employers provide

their employees covered benefits, either directly through a self-administered plan or indirectly through a third party. 29 U.S.C. § 1002(1), (7) (definition of "welfare plan"). The purpose of ERISA's preemption provision, *id.* § 1144(a), is to ensure the primacy of the federal regulatory scheme. The San Francisco law, however, takes aim at the same conduct that ERISA regulates—private employers' provision of health benefits. S.F. Admin. Code § 14.3(a). It plainly relates to ERISA covered plans because whether and how much an employer is required to pay into the City program is directly related to whether the employer has an ERISA plan and if so the level of benefits under that plan. Consequently, it is preempted because it intrudes upon what is supposed to be an exclusively federal scheme. In holding the HCSO not to be preempted, the panel misunderstood the threshold for when an employer establishes an ERISA plan and, in conflict with the statute and prevailing precedent, set the bar for ERISA preemption substantially too high.

The panel inadequately addressed circuit precedents in its analysis of the City-payment option and mischaracterized the Secretary's position

Although it upheld San Francisco's law, the panel failed to identify any way an employer can comply with its spending requirements without creating or altering an ERISA plan, other than through the City-payment option. Whether the City-payment option requires an employer to create an ERISA plan is thus critical because, if it does, there is no question that the City's law is preempted. *See Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 16 (1987); Panel Op. at 13,927. The panel's conclusion that this option severs any possible relationship between the law and ERISA

plans, rendering the law non-preempted, not only overlooks the obvious fact that the HCSO is premised on what the City has determined to be inadequate behavior on the part of some employers in their provision of ERISA-covered health benefits to employees, but, in its analysis of the City-payment option, fails to apply the established test or reach the correct conclusion regarding whether the option itself entails the creation of ERISA plans.

The Secretary argued in support of Golden Gate that the City-payment option meets the test generally used by this and other courts to determine whether an employer has established an ERISA plan. Sec'y Amicus Br. 13-17. Under that relatively low-threshold test, a plan exists if there is an ongoing administrative program and a reasonable person can ascertain the intended benefits, beneficiaries, source of financing, and procedures for receiving benefits. *Id.* at 13 (citing *Winterrowd v. Am. Gen. Annuity Ins. Co.*, 321 F.3d 933, 939 (9th Cir. 2003)). This low-threshold test implements ERISA's objective of a uniform body of benefits law but is also central to accomplishing ERISA's remedial purposes. While it ensures the statute's broad reach it also prevents employers from sponsoring benefit programs "through the purchase of insurance or otherwise" (29 U.S.C. § 1002(1)) that evade ERISA's protective requirements merely due to a lack of formality.

The Secretary explained that when an employer chooses to fund health benefits for its employees by making payments to the City under the HAP program, the employer establishes an ERISA-covered plan for its employees, just as an employer establishes an ERISA-covered plan when it provides health benefits for its employees through the pur-

chase of insurance. *Id.* at 13-14 (citing *Qualls v. Blue Cross of Cal.*, 22 F.3d 839, 843 (9th Cir, 1994) (holding that an employer's purchase of insurance for its employees creates a plan because of the "complex ongoing relationship between the insureds and the insurer which require[s] the constant administrative attention by the insurer").

There is no relevant difference between an employer's decision to provide benefits through HAP or to provide benefits through the purchase of insurance—in both cases, the employees receive their benefits from a third party and the program is substantially administered by a third party. Nothing in the statute or the case law turns on whether the particular benefit arrangement relies upon a private insurer for the administration of benefits, rather than public employees or contractors hired by the City. Whether the employer provides benefits through private insurance or HAP, it has elected an arrangement for providing ERISA-covered benefits to its employees that meets the established test for determining whether a plan exists.

The Secretary agrees with Golden Gate that the panel erred in deviating from the generally-accepted test for determining whether a plan exists and deciding that the case from this Court originally applying that test "is almost certainly no longer good law" in light of *Fort Halifax*. Panel Op. at 13,932 (discussing *Scott*, 754 F.2d at 1503-04). As Golden Gate argues (Pet. for Reh'g 11-12), *Scott* has never been overruled, and the Supreme Court cited *Scott* without disapproval in *Fort Halifax*, 482 U.S. at 7 n.5. The Secretary and other courts of appeals have also generally accepted that test. *See, e.g.*, Sec'y Amicus Br. 13; *Kenney v. Roland Parson Contracting Corp.*, 28

F.3d 1254, 1257 (D.C. Cir. 1994) (citing cases). Indeed, as recently as 2003, in *Winterrowd*, 321 F.3d at 939, this Court reaffirmed the test; it certainly did not hold that the Scott test was no longer good law in light of *Fort Halifax*.[1]

Moreover, the panel erroneously heightened the test for determining when an "ongoing administrative scheme" exists. The Supreme Court has recognized that a state-required "benefit whose regularity of payment necessarily required an ongoing benefit program" necessarily requires administration of a plan. *Fort Halifax*, 482 U.S. at 18 n.12; *see also id.* at 14 n.9 (payment of death benefits requires a plan because "[t]he ongoing, predictable nature of this obligation therefore creates the need for an administrative scheme to process claims and pay out benefits"). The panel required not only conduct sufficient to establish or maintain a plan, but enough employer discretion in the ongoing administration of the arrangement to run the risk of employer mismanagement of funds or other employer abuse. Applying this heightened standard, the Court then concluded that an employer's obligations under the City-payment option do not present the supposedly required risks. Panel Op. at 13,931. By requiring that level of risk, however, the panel altered the standard for determining when a plan exists and failed to address

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[1] Citing dicta from *Sandstrom v. Cultor Food Science, Inc.*, 214 F.3d 795, 797 (7th Cir. 2000), the panel questioned whether the criteria for determining whether a plan exists, first established in *Donovan v. Dillingham*, 688 F.2d 1367, 1373 (11th Cir. 1982) (en banc), survive the requirement in *Fort Halifax* for an ongoing administrative scheme. Panel Op. at 13,934. That requirement is consistent with the *Dillingham* requirement for a reasonably ascertainable claims procedure. See *e.g.*, *Williams v. WCI Steel Co.*, 170 F.3d 598, 604 (6th Cir. 1999).

possible abuses that ERISA was designed to address that could result from employer choice of the City-payment option. *See* Sec'y Amicus Br. 19 (explaining that the City-payment option provides no fiduciary standards to ensure that money employers pay to the City is properly used for employee health accounts or benefits or is subject to any of the constraints imposed by ERISA to protect employees).

The panel's errors, however, run deeper. The panel simply failed to address the Secretary's argument that, under this Court's Qualls decision, a plan may exist even though a third party's responsibility for ongoing administrative activities limits the employer's actual discretion. *See Qualls*, 22 F.3d at 843. It appears that the panel incorrectly viewed the Secretary as arguing that the City-run program was itself a plan. The Secretary never made that argument. Instead, the Secretary argued that an employer who chooses the City-payment option establishes an ERISA plan "in the same manner . . . as when it provides health benefits through the purchase of insurance." Sec'y Amicus Br. 16; *see id.* at 6, 13-17. At oral argument, counsel for the Secretary specifically stated, in response to a question from the Court, that the City-run program was not an ERISA plan. *See* http://www.ca9.uscourts.gov (Audio Files, No. 07-17370, first entry, 44:45 minutes).[2] The Secretary was therefore making the same argument that Golden Gate made, i.e., that ERISA preempts the City-payment option because it requires *employers* to

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[2] Under the Secretary's view, each employer paying the City to partially fund the HAP, thereby guaranteeing its employees access to the HAP's medical benefits under favorable terms, has established a plan, but this does not mean that the HAP is an ERISA plan, making the City a plan sponsor or fiduciary, or the HAP a plan, subject to ERISA.

establish an ERISA plan. *Qualls* is an additional authority that at a minimum is in significant tension with the panel decision: no meaningful distinction can be made between a private insurer acting as a third-party administrator and a public agency or its independent contractor acting as a third-party administrator; and structuring the arrangement as a payment to a government-created entitlement program does not mean the arrangement is not a plan from the employer's perspective or carve out an exception to ERISA preemption that the statute nowhere provides.

The panel failed to apply the Supreme Court's test for determining when a state law interferes with uniform plan administration and reached a result that is inconsistent with the Fourth Circuit's Fielder decision on that issue

The Supreme Court has repeatedly explained that ERISA's preemption provision, 29 U.S.C. § 1144(a), is "intended to ensure that plans *and plan sponsors* would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives *among States* or between States and the Federal Government . . ., [and to prevent] the potential for conflict in substantive law." *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co*, 514 U.S. 645, 656 (1995) (citation omitted) (emphases added). The Supreme Court's test therefore requires an assessment not only of the burdens of the local law at issue but of the potential for conflict if other state or local governments enacted similar laws. *See, e.g.*, *Egelhoff v. Egelhoff*, 532 U.S. 141, 151 (2001). The Supreme Court's test also looks not just to potential burdens on plans and plan

administrators, but to burdens on employers in their capacity as plan sponsors. *See id.* ("This tailoring of plans *and employer conduct* to the peculiarities of the law of each jurisdiction is exactly the burden ERISA seeks to eliminate") (citation and internal quotations omitted; emphasis added).

The Secretary explained to the panel that permitting the City to enforce San Francisco's health care spending requirements creates an obvious potential for conflict with pay-or-play laws that other jurisdictions have enacted or have considered, and imposes an impermissible burden on plan sponsors and administrators to monitor, coordinate, and comply with such differing obligations. Sec'y Amicus Br. 25-28. Golden Gate made a similar argument. Appellee's Answering Br. 27-33. That potential is acute when an employer may be faced not only with having to comply with (or even keep track of) multiple state laws, but with a potentially much greater number of varying municipal laws such as the one San Francisco enacted. Even if the administrative burden imposed by a single law may be tolerable, the cumulative burden could be staggering and runs directly counter to ERISA's goal of encouraging employers, who may operate nationally, voluntarily to provide uniform employee benefits under the legal framework provided by a federal scheme with intentionally broad preemptive force.

The panel nonetheless failed to consider the potential for conflict from other pay-or-play laws. Pet. for Reh'g En Banc 14-15. Instead, it simply stated that San Francisco's HCSO does not impose "on plan administrators" any burden of complying with conflicting directives relating to benefits law, without providing any analysis of how other pay-or-play laws

may differ and interact. Panel Op. at 13,942. It also failed to consider burdens on employers as *plan sponsors*. It recognized that the law imposes burdens on employers, but decided that they are permissible because "these burdens exist whether or not a covered employer has an ERISA plan. Thus, they are burdens on the employer rather than on an ERISA plan." *Id.* Under a proper analysis, the panel should have considered the burdens the HCSO imposes on employers who already have or may establish ERISA plans (i.e., plan sponsors) and determined that it interferes with their ability to maintain plan uniformity to the extent they operate in different jurisdictions.

Accordingly, the panel's decision conflicts with the Fourth Circuit's analysis of the uniformity issue in *Fielder*. As Golden Gate explains in its rehearing petition (Pet. for Reh'g En Banc 15-16), there were two holdings in the Fourth Circuit's conclusion that ERISA preempts Maryland's Fair Share Health Care Fund Act, which required certain large employers to spend 8% of their payroll for employee health care or pay the shortfall to the state Medicaid fund. First, the court held that ERISA preempts the law because the law effectively mandated that covered employers pay for health care for their employees because no rational employer would pay the state rather than cover its own employees directly. *Fielder*, 475 F.3d at 193-94. Second, the court held that employers had no meaningful other way to pay for their employees' health care without affecting ERISA plans but even if there were a meaningful non-ERISA way to comply with the law, "we would still conclude that the Fair Share Act had an impermissible 'connection with' ERISA plans." *Id.* at 196. The court reasoned that because "the vast majority of any employer's health-

care spending occurs through ERISA plans . . . the primary subjects of the [law] are ERISA plans, and any attempt to comply with the [law] would have direct effects on the employer's ERISA plans." *Id.* The court further reasoned that "a proliferation of similar laws in other jurisdictions would force [employers] to monitor these varying laws and manipulate [their] healthcare spending to comply with them, and that such effects would deny covered employers a uniform nationwide administration of their healthcare plans." *Id.* at 197.

The panel's decision addresses only the Fourth Circuit's rejection of the state-payment option as a realistic way to comply with the Maryland law at issue in Fielder. Panel Op. at 13,946-49. However, the panel failed to address the Fourth Circuit's conclusion that even if an employer has meaningful ways to comply with a healthcare spending requirement without affecting ERISA plans, the law is still preempted because of its interference with the employer's ability to administer a uniform nationwide healthcare plan. Rehearing en banc is warranted because the panel's finding of no preemption is inconsistent with the Fourth Circuit's correct analysis on the uniformity issue.

CONCLUSION

The petition for rehearing en banc should be granted.

Respectfully submitted.

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APPENDIX D

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

No. C06-06997JSW

GOLDEN GATE RESTAURANT, ASSOCIATION,
Plaintiff,

v.

CITY AND COUNTY OF SAN FRANCISCO and DOES 1-15,
Defendants.

Now before the Court are the cross motions for summary judgment filed by Plaintiff Golden Gate Restaurant Association ("Plaintiff) and the City and County of San Francisco ("the City"). Intervenors San Francisco Central Labor Council, Service Employees International Union Local 1021, SUIU United Healthcare Workers-West and Unite-Here!, Local 2 (collectively "the Intervenors") have also moved for summary judgment on behalf of the City and have joined in the City's opposition to Plaintiffs motion. Having considered the parties' pleadings, the relevant legal authority, and having had the benefit of oral argument, the Court hereby GRANTS Plaintiffs motion for summary judgment and DENIES the City's and the Intervenors' motion for summary judgment.

BACKGROUND

In 2006, the San Francisco Board of Supervisors unanimously passed, and the Mayor signed into law, the San Francisco Health Care Security Ordinance

(the "Ordinance"). The Ordinance contains two key components related to the regulation of health care in San Francisco. The first is an employer health spending requirement and the second, is a government health care program, funded in part by those employer contributions. The employer spending requirement, which does not become operative until January 1, 2008, is the subject of the pending suit and mandates that medium and large businesses make minimum health care expenditures on behalf of covered employees. Specifically, in 2008, a private employer with between 20 and 99 employees and a nonprofit with 50 or more employees would, for any employee who has been employed for 90 days and works more than 10 hours per week, make health care expenditures of $1.17 per hour on behalf of that employee. Ord. § 14.1(b)(8); Reg. No. 5.2(A)(2). A private employer with 100 or more employees would make health care expenditures of $1.76 per hour on behalf of each covered employee. Ord. § 14(b)(8); Reg. No. 5.2(A)(1).

The Ordinance sets out a number of non-exclusive qualifying health care expenditures, such as contributions to health savings accounts, direct reimbursement to employees for some of the expenses incurred in the purchase of health care services, payments to third parties for the purpose of provided health care services, costs incurred in the direct delivery of health care services, or payments by the employer to the City "to be used on behalf of covered employees." Ord. § 14.1(b)(7).

The Ordinance also establishes a government health care program operated by the Department of Public Health. Using the expenditures paid by private employers, individuals, and contributions from

the City, the Ordinance creates a City fund to operate a Health Access Program ("HAP"). Ord. § 14.2(d). The HAP would deliver health care to its participants from a network consisting of San Francisco General Hospital, Department of Health clinics, and participating non-profit and private providers. Ord. § 14.2(a). The HAP, funded in part by the City's general fund and in part by the employer's contributions, would be available to uninsured San Francisco residents, regardless of their employment status. Enrollees would pay quarterly participation fees on a sliding scale basis. Nonresidents who work in the City would not qualify for HAP participation, but the program would set up a medical reimbursement account and those nonresident employees could draw from the account to obtain reimbursement for medical expenses, including the payment of health insurance premiums. Ord. §§ 14.1(b)(7), 14.2(g).

Employers covered by the Ordinance would be required to maintain "accurate records of health care expenditures" and "proof of such expenditures," allow "reasonable access" by City officials to such records, and annually report "such other information" that the City requires. Ord. § 14.3(b). The Ordinance also requires that all employers avoid reducing their workforce below any of the Ordinance thresholds or prove that the reduction was not done to avoid the thresholds. Ord. § 14.4(c). Violation of any of these requirements could result in significant penalties and presumptions against employers. Ord. § 14.3(b). The City would be able to collect penalties through administrative enforcement or via a civil action for penalties, costs and attorneys' fees. Ord. § 14.4(e)(3).

Golden Gate Restaurant Association, a group established to promote, extend and protect the general

interests of the restaurant industry, brought suit on November 8, 2006, seeking declaratory and injunctive relief on the theory that the Ordinance's spending requirement is preempted by ERISA. The parties cross-moved for summary judgment on that legal issue.

The Court shall address additional facts as necessary to its analysis in the remainder of this Order.

ANALYSIS

LEGAL STANDARD.

A court may grant summary judgment as to all or a part of a party's claims. Fed. R. Civ. P. 56(a). Summary judgment is proper when the "pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(c). An issue is "genuine" only if there is sufficient evidence for a reasonable fact finder to find for the non-moving party. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248-49 (1986). A fact is "material" if the fact may affect the outcome of the case. *Id.* at 248. "In considering a motion for summary judgment, the court may not weigh the evidence or make credibility determinations, and is required to draw all inferences in a light most favorable to the non-moving party." *Freeman v. Arpaio*, 125 F.3d 732, 735 (9th Cir. 1997).

A principal purpose of the summary judgment procedure is to identify and dispose of factually unsupported claims. *Celotex Corp. v. Cattrett*, 477 U.S. 317, 323-24 (1986). The party moving for summary judgment bears the initial burden of identifying those portions of the pleadings, discovery, and affidavits

which demonstrate the absence of a genuine issue of material fact. *Id.* at 323. Where the moving party will have the burden of proof on an issue at trial, it must affirmatively demonstrate that no reasonable trier of fact could find other than for the moving party. *Id.* Once the moving party meets this initial burden, the non-moving party must go beyond the pleadings and by its own evidence "set forth specific facts showing that there is a genuine issue for trial." Fed. R. Civ. P. 56(e). The non-moving party must "identify with reasonable particularity the evidence that precludes summary judgment." *Keenan v. Allan*, 91 F.3d 1275, 1279 (9th Cir. 1996) (quoting *Richards v. Combined Ins. Co.*, 55 F.3d 247, 251 (7th Cir. 1995)) (stating that it is not a district court's task to "scour the record in search of a genuine issue of triable fact"). If the non-moving party fails to make this showing, the moving party is entitled to judgment as a matter of law. *Celotex*, 477 U.S. at 323.

Whether ERISA acts to preempt a state or local law is a question of law. *Farr v. US. West Communications, Inc.*, 151 F.3d 908, 913 (9th Cir. 1998). Under the provisions of ERISA, "State law" includes "all laws, decisions, regulations, or other State action having the effect of law," while "State" includes "any political subdivisions thereof, or any agency or instrumentality of either, which purpose to regulate, directly or indirectly, the terms and conditions of em ployee benefit plans covered by [ERISA]." 29 U.S.C. §§ 1144(c)(1), (c)(2). For purposes of the analysis, "the constitutionality of local ordinances is analyzed in the same way as that of statewide laws." *Hillsborough County v. Automated Medical Laboratories, Inc.*, 471 U.S. 707, 713 (1985).

ERISA PREEMPTION.

Congress enacted the Employee Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.*, as a comprehensive legislative scheme "to promote the interests of employees and their beneficiaries in employee benefit plans." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983). By enacting such a broad scheme, Congress also sought to protect employers by "eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans." *Id.* at 99. To further this goal of nationwide uniformity and consistency, Congress included a preemption clause, section 514(a), which "conspicuous for its breadth, it establishes as an area of exclusive federal concern the subject of every state law that 'relate[s] to' an employee benefit plan governed by ERISA." *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990). The clause is considered "one of the broadest preemption clauses ever enacted by Congress." *PM Group Life Insurance Co. v. Western Growers Assurance Trust*, 953 F.2d 543, 545 (9th Cir. 1992).

Section 514(a) provides that ERISA "supercede[s] any and all State laws insofar as they now or hereafter relate to any employee benefits plan." 29 U.S.C. § 1144(a). The majority of health care options provided for employees by private employers qualify as an "employee welfare benefit plan," defined by ERISA as "any plan, fund, or program which . . . was established or is maintained for the purpose of providing its participants or their beneficiaries, through the purchase of insurance or otherwise, . . . medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident [or] disability . . . . " 29 U.S.C. § 1002(1).

State laws are preempted by ERISA "insofar as they may now or hereafter relate to any employee benefit plan" regulated by ERISA. 29 U.S.C. § 1144(a). "But before a court wades into this provision's 'veritable Sargasso Sea of obfuscation,' it must first resolve the simpler question of whether a party may assert a claim under ERISA." *Miller v. Rite Aid Corp.*, 504 F.3d 1102, 1105 (9th Cir. 2007) (citing *Toumajian v. Frailey*, 135 F.3d 648, 653 n.3 (9th Cir.1998) (citation and internal quotation marks omitted)). The task of developing a clear rule to identify whether ERISA preempts a particular state law "has bedeviled the Supreme Court." *Rutledge v. Seyfarth, Shaw, Fairweather & Geraldson*, 201 F.3d 1212, 1216 (9th Cir. 2000) (citing *Dillingham*, 519 U.S. at 335) (1997) (Scalia, J., concurring) ("Since ERISA was enacted in 1974, this Court has accepted certiorari in, and decided, no less than 14 cases to resolve conflicts in the Courts of Appeals regarding ERISA pre-emption of various sorts of state law. The rate of acceptance, moreover, has not diminished . . . ") (footnote omitted)).

The language of ERISA's preemption provision—covering all laws that relate to an ERISA plan—is clearly expansive. *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655 (1995). A state law relates to an ERISA employee benefit plan "if it has a connection with or reference to such a plan." *Shaw*, 463 U.S. at 97. The analysis of whether a state law is preempted by ERISA follows one of two paths—if the law is either found to be connected with or to make reference to an ERISA plan, the law is found to be preempted.

"A state law that 'relates to' an ERISA plan is preempted by ERISA even if the law is not specifi-

cally designed to affect such [a] plan . . . , or the effect is only indirect.' *Aloha Airlines v. Ahue*, 12 F.3d 1498, 1504 (9th Cir. 1993) (citing *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 139 (1990)). Only those state laws that "relate to" ERISA plans are preempted. *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 23 (1987). Although the text of the ERISA preemption provision is clearly expansive, courts have recognized that the term "relate to" cannot be "taken to extend to the furthest stretch of its indeterminancy," or else "for all practical purposes preemption would never run its course." *Travelers*, 514 U.S. at 655. Indeed, "applying the 'relate to' provision according to its terms was a project doomed to failure, since, as many a curbstone philosopher has observed, everything is related to everything else." *California Division of Labor Standards Enforcement v. Dillingham Construction*, 519 U.S. 316, 335 (1997). "Some state actions may affect employee benefit plans in too tenuous, remote or peripheral a manner to warrant a finding that the law 'relates to' the plan." *Shaw*, 463 U.S. at 100 n.21; *Aloha Airlines*, 12 F.3d at 1504. Accordingly, the Court cannot rely on "uncritical literalism" but must rather attempt to ascertain whether Congress would have expected the particular statute at issue to be preempted. *Travelers*, 514 U.S. at 656.

In order to evaluate whether the normal presumption against preemption has been overcome in any particular case, the Court "must go beyond the unhelpful text and the frustrating difficulty of defining its key term, and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." *Id.* To determine Congressional intent, the Court must examine the "objectives of the ERISA statute" and

"the nature of the effect of the state law on ERISA plans." *Dillingham*, 519 U.S. at 325. In analyzing the basic objectives of Congress in passing the broad preemption clause of ERISA, the Supreme Court has found that the "basic thrust of the pre-emption clause [is] to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans." Travelers, 514 U.S. at 657. The Court has also emphasized more generally that the "principal object of the statute [ERISA] is to protect plan participants and beneficiaries." *Boggs v. Boggs*, 520 U.S. 833, 845 (1997).

However, "the Court has established a presumption that Congress did not intend ERISA to preempt areas of traditional state regulation that are quite remote from the areas with which ERISA is expressly concerned—reporting, disclosures, fiduciary responsibility, and the like." *Rutledge*, 201 F.3d at 1217 (internal citations omitted). The Court has repeatedly held that we "must presume that Congress did not intend to preempt areas of traditional state regulation." *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 740 (1985). Where "federal law is said to bar state action in fields of traditional state regulation . . . we have worked on the 'assumption that the historic police powers of the States were not to be superceded by the Federal Act unless that was the clear and manifest purpose of Congress.' *Travelers*, 514 U.S. at 655 (quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947)). In particular, ERISA was not intended to supplant state law, especially in cases involving "fields of traditional state regulation," which include "the regulation of matters of health and safety." *DeBuono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 814 n.8 (1997) (citations omitted). "[N]othing in the language of [ERISA] or

the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern." *Travelers*, 514 U.S. at 662 (citing *Hillsborough County v. Automated Medical Laboratories, Inc.*, 471 U.S. 707, 719 (1985)).

However, the Supreme Court has regularly stated that the preemption clause of ERISA "indicates Congress's intent to establish the regulation of employee welfare benefit plans 'as exclusively a federal concern." *Travelers*, 514 U.S. at 656 (citing *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981)). Any state law that mandates employee benefit structures or their administration is preempted by ERISA. *Travelers*, 514 U.S. at 658. Such state-imposed regulation of employers' provision of employee benefits conflicts with ERISA's goal of establishing uniform, nationwide regulation of employee benefit plans. *Retail Industry Leaders Association v. Fielder*, 475 F.3d 180, 191 (4th Cir. 2007) (citing *Travelers*, 514 U.S. at 657-58).

The standard of whether a state law is preempted by ERISA because it makes reference to an ERISA plan applies more narrowly. The Court must examine the text of the statute to determine whether its own terms bring ERISA plans under its operation. *See Dillingham*, 519 U.S. at 325 (explaining that a state law contains a "reference to" an ERISA plan if it "acts immediately and exclusively upon ERISA plans" or if "the existence of ERISA plans is essential to the law's operation."); *see also District of Columbia v. Greater Washington Bd. of Trade*, 506 U.S. 125, 128 (1992) (invalidating a law that required an employer who provides health insurance coverage for an employee to provide the equivalent insurance while the

employee was receiving workers compensation benefits). ERISA preempts state laws that relate to employee benefit plans even if they only indirectly affect those plans. *Ingersoll-Rand*, 498 U.S. at 139.

THE ORDINANCE IS PREEMPTED BY HAVING A CONNECTION TO AND MAKING UNLAWFUL REFERENCE TO EMPLOYEE BENEFIT PLANS.

The Ordinance's health care expenditure requirements are preempted because they have an impermissible connection with employee welfare benefit plans. By mandating employee health benefit structures and administration, those requirements interfere with preserving employer autonomy over whether and how to provide employee health coverage, and ensuring uniform national regulation of such coverage. The Ordinance's provisions also make unlawful reference to benefit plans because they refer to, are designed to act immediately upon, and cannot operate successfully without the existence of employee welfare benefit plans.

ERISA was promulgated, among other reasons, to set uniform standards, including "rules concerning reporting, disclosure and fiduciary responsibility." *Shaw*, 463 U.S. at 91. The statute enables employers to adopt, modify or terminate welfare plans, in accordance with national standards, and mandates that "private parties, not the Government, control the level of benefits" under ERISA plans. *Alessi*, 451 U.S. at 511. ERISA enables private employers to set and maintain employee benefit plans in order to encourage employers to set higher benefit levels by streamlining administration and decreasing employee benefit plan costs. *Inter-Modal Rail Employees Association v. Atchison, Topeka & Santa Fe*

Railway, 520 U.S. 510, 515 (1997). Although the City contends that the Ordinance's health care expenditure requirements do not necessarily affect the levels contributed to any specific private employer's ERISA plan, the Court finds that the Ordinance affects plan administration, a core area of ERISA concern.

> (1) whether the state law regulated certain ERISA relationships, including relationships between an ERISA plan and employer and, to the extent an employee benefit plan is involved, between the employer and the employee.

The Court does not find the second factor indicates a connection between the statute and ERISA plans. Although the Ordinance's creation of the City's Health Access Program resembles an alternate ERISA plan in some ways, the Court is not persuaded that the separate public health care plan envisioned by the Ordinance actually creates a separate *de facto* ERISA plan.

Third, the requirements of the Ordinance have an impermissible connection with employee benefit plans because they impose on employers specific recordkeeping, inspection and other administrative burdens related to the administration of their private healthcare expenditures. The Ordinance requires employers to maintain accurate records of all health care expenditures, allow the City access to all such records, and provide information regarding health care expenditures to the City on an on-going basis, including "such other information" as the City may require. Ord. § 14.3(b). The Ordinance also requires the City's Office of Labor Standards Enforcement to create procedures "for covered employees to maintain accurate records" and to "provide a report to the

City." Ord. § 14.4(a). Failure by an employer to maintain accurate records, to prepare an annual report detailing employer-provided health care expenses, or to permit the audit and inspection of its records subjects an employer to substantial daily penalties. Ord. §§ 14.3(b), 14.4(e)(2).

The parties contest the extent of the administrative recordkeeping requirements and debate the complexity and extent of the necessary mathematical computations to determine compliance with the expenditure requirements. Whether the computations are complex or simple, the requirements on employers under the Ordinance are ongoing and directly affect the administrative scheme of providing healthcare benefits. *See Aloha Airlines*, 12 F.3d at 1505 (holding that state and local laws that singled out employer-provided health care costs and required reports of such costs were preempted for several reasons, including that because the state statute "creates potential reporting requirements for [the plaintiffs] ERISA plans, . . . and prompts disclosure and funding requirements, as outlined in *Shaw*, it satisfies the 'relates to' [ERISA preemption] standard."); *contra Patel v. Sugen, Inc.*, 354 F. Supp. 2d 1098, 1105 (N.D. Cal. 2005) (citing *Delaye v. Agripac, Inc.*, 39 F.3d 235, 237 (9th Cir. 1994) (no preemption where employer is required only to make a single arithmetical calculation to determine eligibility for questioned scheme)).

Lastly, the Court is persuaded that the Ordinance directly and indirectly affects the structure and administration of ERISA plans. The expenditure requirements affect the structure of private employers' already existing plans by requiring that, in order to comply with the City's additional requirements,

employers either modify the administration of their existing ERISA plans or structure their additional payments with reference to the amounts paid under the existing plans. "[E]ven if [options provided by statute] were a meaningful avenue by which [the employer] could incur non-ERISA healthcare spending, we would still conclude that the [statute] had an impermissible 'connection with' ERISA plans. The undeniable fact is that the vast majority of any employer's healthcare spending occurs through ERISA plans. Thus, the primary subjects of the [statute] are ERISA plans, and any attempt to comply with the [statute] would have direct effects on the employer's ERISA plans." Fielder, 475 F.3d at 196; *see also Egelhoff v. Egelhoff*, 532 U.S. 141, 147-48 (2001) (holding that a Washington state statute that binds ERISA plan administrators to a particular choice of rules for determining beneficiary status has an impermissible "connection with" ERISA, as the statute "implicates an area of core ERISA concern").

The requirements directly and indirectly affect the relationship between private employers and the provision of health care coverage, a relationship that has traditionally been governed by ERISA. After distilling a number of the various tests utilized in the Ninth Circuit to determine the question of preemption, the *Rutledge* court observed that under each test, "a core factor leading to the conclusion that a state law is preempted is that the claim bears on an ERISA-regulated relationship." 201 F.3d at 1219 (citing *Blue Cross of California v. Anesthesia Care Associates*, 187 F.3d 1045, 1053 (9th Cir. 1999) ("[W]e look to whether the state law encroaches on relationship regulated by ERISA . . . . "); *Emard v. Huges Aicraft Co.*, 153 F.3d 949, 957 (9th Cir. 1998) (In determining whether state law would "frustrate the

purposes" of the statute, a factor is the existence of state-law regulation of ERISA relationships.); *Operating Engineers*, 135 F.3d at 678 (A preemption factor is "whether the state law regulates certain ERISA relationships . . . . ") (quoting *Aloha Airlines, Inc.* (internal quotation marks omitted))); *Geweke Ford v. St. Joseph's Omni Preferred Care Inc.*, 130 F.3d 1355, 1358 (9th Cir. 1997) ("A state law claim is preempted if it 'encroaches on the relationships regulated by ERISA.'" (citation omitted); *see also Arizona State Carpenters Pension Trust Fund v. Citibank (Arizona)*, 125 F.3d 715, 724 (9th Cir. 1997) (holding that there is no preemption where, *inter alia*, the state laws "do not affect the relationships between the principal ERISA participants"). The Court finds that the Ordinance requires the modification of the core relationship between the private employers and their intended health care beneficiaries. In order to comply with the expenditure requirements, employers would either have modify the administration of their existing ERISA plans where the current payments are below the threshold or structure their additional payments by making unlawful reference to the amounts paid under existing ERISA plans.

Also, the Ordinance has a prohibited connection with ERISA plans because it interferes with nationally uniform plan administration. One of the principal goals of ERISA is to enable employers "to establish a uniform administrative scheme, which provides a set of claims and disbursements of benefits." *Fort Halifax Packing*, 482 U.S. at 9. Uniformity is made impossible where ERISA plans are subject to different legal obligations in different states or local jurisdictions. *Egelhoff* 532 U.S. at 148. "Requiring ERISA administrators to master the relevant laws of 50 States and to contend with litigation would

undermine the congressional goal of 'minimiz[ing] the administrative and financial burden[s]' on plan administrators—burdens ultimately borne by the beneficiaries." *Id.* at 149 (citing *Ingersoll-Rand*, 498 U.S. at 142). The "tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction" is exactly the burden ERISA seeks to eliminate. *Ingersoll-Rand*, 498 U.S. at 142. "The [statute] would deny [the employer] the uniform nationwide administration of its healthcare plans by requiring it to keep an eye on conflicting state and local minimum spending requirements and adjust its healthcare spending accordingly." *Fielder*, 475 F.3d at 197. If the expenditure requirements of the Ordinance were not considered preempted by ERISA, employers would necessarily have to keep an eye on the minimum heath care spending requirements in each locality in order to comply with potentially conflicting requirements. Mandating this type of varied compliance—both with the substantive minimum benefits levels requirements and the administrative reporting, recordkeeping and disclosure requirements—conflicts with ERISA's promise to "provide a uniform regulatory regime over employee benefit plans." *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004); Shaw, 463 U.S. at 98-100.

In addition, the Court finds that the provisions of the Ordinance make unlawful reference to employee benefit plans. First, the statute specifically references the existence of ERISA plans in its expenditure requirements provisions. Ord. § 14.1(b)(7) (calculating employer liability by looking at "amounts paid by a covered employer to its covered employees or to a third party . . . for the purpose of providing health care services for covered employees."); Final Regs. § 6.2(E) (specifically referring to different types of

ERISA plans, and providing that employers do not receive credit if an employee declines coverage under a plan "that requires contributions by a covered employee."). In addition, liability under the Ordinance is determined exclusively with reference to employer-provided health benefits, mostly under existing ERISA plans, which plans are essential to the operation of the Ordinance. *See Fielder*, 475 F.3d at 196 ("The undeniable fact is that the vast majority of any employer's healthcare spending occurs through ERISA plans. Thus, the primary subjects of the [statute] are ERISA plans, and any attempt to comply with the [statute] would have direct effects on the employer's ERISA plans.") The expenditure requirements take into account directly whether and how much employers are spending on employee health coverage. The Ordinance requires that the employer examine the amounts "paid by a covered employer to its covered employees or to a third party . . . for the purpose of providing health care services for covered employees." Ord. § 14.1(b)(7). In order to enforce the spending provisions of the Ordinance, the City must examine whether employers provide ERISA-governed benefits. In order to determine compliance, the Ordinance necessarily refers to whether and how much an employer pays for employee health coverage under its existing ERISA plans, assuming such employers maintain them at all.

This Court finds that such a structure is akin to the statute the Supreme Court found preempted in *District of Columbia v. Greater Washington Board of Trade* which required the employer to provide the same amount of health care coverage for workers eligible for workers compensation. 506 U.S. at 128. The Court found that the employers' existing health care coverage was subject to ERISA and "any state

law imposing requirements by reference to such covered programs must yield to ERISA . " *Id.* at 130-31. Similarly, here, the Ordinance requires hat private employers pay a certain threshold amount to their covered employees, making specific reference to the amounts already paid through private ERISA plans. The mechanism for determining compliance with the expenditure requirements specifically takes into account the amount already spent in private plans subject to ERISA . As discussed *infra*, the structure of the private plans would necessarily be affected by the substantive expenditure requirements as well as he administration of maintaining and demonstrating compliance.

Defendants rely heavily on the decision in *WSB Electric, Inc. v. Curry*, in which the Ninth Circuit found that the two-tier approach of the California regulation of wages was not preempted by ERISA. 88 F.3d 788, 791, 796 (9th Cir. 1996). The court found that the statute which required public works contractors to pay a minimum level of cash compensation and then credited certain benefits paid by those contractors toward that level did not have an impermissible effect on ERISA plans because California's "scheme d[id] not force employers to provide any particular employee benefits . . . or to even provide . . . employee benefits at all." *Id.* at 793-94. Instead, the law gave credit for both wages and benefits when determining employers' compliance. *Id.* at 790-91; *see also Associated Builders & Contractors of S. Cal. v. Nunn*, 356 F.3d 979, 986 (9th Cir. 2004) (holding that wage statute was not preempted where rates could be satisfied by a mixture of wages and benefits). The *WSB* court distinguished the statute in *Greater Washington* which was preempted because "it imposed an obligation upon an employer that was

'measured by reference' to he level of benefit provided by that employer under an ERISA plan." *WSB*, 88 F.3d at 792-93 (citing *Greater Washington*, 506 U.S. at 128132). In contrast, the prevailing wage statute at issue in WSB merely referenced ERISA plans by taking them into account when calculating the cash wage hat must be paid to comply. *Id.* at 793. "The scheme does not force employers to provide any particular employee benefits or plans, to alter their existing plans, or to even provide ERISA plans or employee benefits at all." *Id.* (citing *Employee Staffing Services, Inc. v. Aubry*, 20 F.3d 1038, 1041 (9th Cir. 1994)). The *WSB* court held that "a statute 'refers to' an ERISA plan and is preempted if it mentions or alludes to ERISA plans, *and* has some effect on the referenced plans." *WSB*, 88 F.3d at 793.

The holding in *WSB* specifically referred to the calculation of wages, which were to include benefits as part of the total. *Id.* The Ordinance before this Court, however, would require that private employers calculate not wages but benefits available to any covered employee. Not only are these benefits the type already regulated by ERISA, but the analysis required to determine both whether an employee is covered and the amount the employee would be entitled to under the Ordinance with specific reference to amounts already paid under private ERISA plans, would alter the administration of existing private ERISA plans. As a separate spending requirement, apart from any required wages or other benefits, the Ordinance requires a certain threshold payment to ERISA plans or alternatively to the City. In addition, the Court finds that Ordinance's requirements affect the relationship between private employers and the provision of health care coverage. Therefore, according to the somewhat modified test

set out in *WSB*, the Court finds that the statute refers to ERISA plans because it both "mentions and alludes to ERISA plans, and has some effect on the referenced plans." *See id.*

Accordingly, under either analysis, the Ordinance is preempted because it has both a connection with and references ERISA plans.

CONCLUSION

For the foregoing reasons, the Court GRANTS Plaintiffs motion for summary judgment and DENIES the City's and the Intervenors' motions for summary judgment. State laws are preempted by ERISA "insofar as they may now or hereafter relate to any employee benefit plan" regulated by ERISA. 29 U.S.C. § 1144(a). The various cases interpreting the scope of ERISA preemption have established that a state law is preempted where it is related to ERISA plans, that is, where it either has a connection to or makes reference to such plans. Considering the scope of

However, as the Court noted at oral argument in this matter, the goal of providing health care for the people of San Francisco, as well as the nation, is a laudable one. On the other hand, Congress I as evinced its intent to preclude state or local governments from passing any legislation that elate to ERISA plans so as to avoid a patchwork of state and local health care programs across the nation. The Court is not convinced that other alternatives for creating a program for providing public health care are not viable. Defendants propose an increased general tax requirement, but state the unfairness of not taking existing health care expenditures into account. Without wading into the legislative dominion,

the Court can envision such a tax program that takes existing health care expenditures by private employers into account in the form of tax credits. Further, as the parties allude, there are alternatives such as funding a public health care system by requiring a hourly rate paid to the City. (*See* Intervenors' Motion at 6-7; Opp. Br. at 10 n.8.) Whatever the legislative solution to the problem facing our nation of providing adequate health care, the Court must nevertheless conclude that the San Francisco Ordinance fails to withstand the expansive test of RISA preemption.

IT IS SO ORDERED

Dated: December 26, 2007 /s/ _____
JEFFREY S. WHITE
UNITED STATES
DISTRICT JUDGE

APPENDIX E

ERISA section 2(a), 29 U.S.C. § 1001. Congressional findings and declaration of policy

(a) Benefit plans as affecting interstate commerce and the Federal taxing power. The Congress finds that the growth in size, scope, and numbers of employee benefit plans in recent years has been rapid and substantial; that the operational scope and economic impact of such plans is increasingly interstate; that the continued well-being and security of millions of employees and their dependents are directly affected by these plans; that they are affected with a national public interest; that they have become an important factor affecting the stability of employment and the successful development of industrial relations; that they have become an important factor in commerce because of the interstate character of their activities, and of the activities of their participants, and the employers, employee organizations, and other entities by which they are established or maintained; that a large volume of the activities of such plans is carried on by means of the mails and instrumentalities of interstate commerce; that owing to the lack of employee information and adequate safeguards concerning their operation, it is desirable in the interests of employees and their beneficiaries, and to provide for the general welfare and the free flow of commerce, that disclosure be made and safeguards be provided with respect to the establishment, operation, and administration of such plans; that they substantially affect the

revenues of the United States because they are afforded preferential Federal tax treatment; that despite the enormous growth in such plans many employees with long years of employment are losing anticipated retirement benefits owing to the lack of vesting provisions in such plans; that owing to the inadequacy of current minimum standards, the soundness and stability of plans with respect to adequate funds to pay promised benefits may be endangered; that owing to the termination of plans before requisite funds have been accumulated, employees and their beneficiaries have been deprived of anticipated benefits; and that it is therefore desirable in the interests of employees and their beneficiaries, for the protection of the revenue of the United States, and to provide for the free flow of commerce, that minimum standards be provided assuring the equitable character of such plans and their financial soundness.

ERISA section 3(1), 29 U.S.C. § 1002(1). Definitions

(1) The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise,

(A) medical, surgical, or hospital care or benefits, or benefits in the event of sick-

ness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or

(B) any benefit described in section 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions).

ERISA section 514(a), (b), 29 U.S.C. § 1144(a), (b).
Other law

(a) Supersedure; effective date. Except as provided in subsection (b) of this section, the provisions of this title and title IV shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in Section 4(a) and not exempt under Section 4(b). This section shall take effect on January 1, 2975.

(b) Construction and application.

(1) This section shall not apply with respect to any cause of action which arise, or any act or omission which occurred, before January 1, 1975.

(2)(A) Except as provided in subparagraph (B), nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

APPENDIX F

CHAPTER 14. SAN FRANCISCO HEALTH CARE SECURITY ORDINANCE

Sec. 14.1. Short Title; Definitions.

Sec. 14.2. San Francisco Health Access Program and Reimbursement Accounts.

Sec. 14.3. Required Health Care Expenditures.

Sec. 14.4. Administration and Enforcement.

Sec. 14.5. Severability.

Sec. 14.6. Preemption.

Sec. 14.7. General Welfare.

Sec. 14.8. Operative Date.

SEC. 14.1. SHORT TITLE; DEFINITIONS.

(a) Short title. This Chapter shall be known and may be cited as the "San Francisco Health Care Security Ordinance."

(b) Definitions. For purposes of this Chapter, the following terms shall have the following meanings:

(1) "City" means the City and County of San Francisco.

(2) "Covered employee" means any person who works in the City where such person qualifies as an employee entitled to payment of a minimum wage from an employer under the Minimum Wage Ordinance as provided under Chapter 12R of the San Francisco Administrative Code and has performed work for compensation for his or her employer for ninety (90) days, provided, however, that:

(a) From the effective date of this Chapter through December 31, 2007, "at least twelve (12) hours" shall

be substituted for "at least two (2) hours" where such term appears in Section 12R.3(a);

(b) From January 1, 2008 through December 31, 2008, "at least ten (10) hours" shall be substituted for "at least two (2) hours" where such term appears in Section 1 2R.3 (a);

(c) Beginning January 1, 2009, "at least eight (8) hours" shall be substituted for "at least two (2) hours" where such term appears in Section 12R.3(a);

(d) The term "employee" shall not include persons who are managerial, supervisorial, or confidential employees, unless such employees earn annually under $72,450.00 or in 2007 and for subsequent years, the figure as set by the administering agency;

(e) The term "employee" shall not include those persons who are eligible to receive benefits under Medicare or TRICARE/CHAMPUS;

(f) The term "covered employees" shall not include those persons who are "covered employees" as defined in Section 12Q.2.9 of the Health Care Accountability Ordinance, Chapter 12Q of the San Francisco Administrative Code, if the employer meets the requirements set forth in Section 12Q.3 for those employees; and

(g) The term "covered employees" shall not include those persons who are employed by a nonprofit corporation for up to one year as trainees in a bona fide training program consistent with Federal law, which training program enables the trainee to advance into a permanent position, provided that the trainee does not replace, displace, or lower the wage or benefits of any existing position or employee.

(h) Nor shall "covered employees" include those persons whose employers verify that they are receiving health care services through another employer, either as an employee or by virtue of being the spouse, domestic partner, or child of another person; provided that the employer obtains from those persons a voluntary written waiver of the health care expenditure requirements of this Chapter and that such waiver is revocable by those persons at any time.

(3) "Covered employer" means any medium-sized or large business as defined below engaging in business within the City that is required to obtain a valid San Francisco business registration certificate from the San Francisco Tax Collector's office or, in the case of a nonprofit corporation. an employer for which an average of fifty (50) or more persons per week perform work for compensation during a quarter. Small businesses are not "covered employers" and are exempt from the health care spending requirements under Section 14.3.

(4) "Employer" means an employing unit as defined in Section 135 of the California Unemployment Insurance Code or any person defined in Section 18 of the California Labor Code. "Employer" shall include all members of a "controlled group of corporations" as defined in Section 1563(a) of the United States Internal Revenue Code, and the determination shall be made without regard to Sections 1563(a)(4) and 1563 (e)(3)(C) of the Internal Revenue Code.

(5) "Health Access Program" means a San Francisco Department of Public Health program to provide health care for uninsured San Francisco residents.

(6) "Health Access Program participant" means any uninsured San Francisco resident, regardless of em-

ployment or immigration status or pre-existing condition, who is enrolled by his or her employer or who enrolls as an individual in the Health Access Program under the terms established by the Department of Public Health.

(7) "Health care expenditure" means any amount paid by a covered employer to its covered employees or to a third party on behalf of its covered employees for the purpose of providing health care services for covered employees or reimbursing the cost of such services for its covered employees, including, but not limited to (a) contributions by such employer on behalf of its covered employees to a health savings account as defined under section 223 of the United States Internal Revenue Code or to any other account having substantially the same purpose or effect without regard to whether such contributions qualify for a tax deduction or are excludable from employee income; (b) reimbursement by such covered employer to its covered employees for expenses incurred in the purchase of health care services; (c) payments by a covered employer to a third party for the purpose of providing health care services for covered employees; (d) costs incurred by a covered employer in the direct delivery of health care services to its covered employees; and (e) payments by a covered employer to the City to be used on behalf of covered employees. The City may use these payments to: (i) fund membership in the Health Access Program for uninsured San Francisco residents; and (ii) establish and maintain reimbursement accounts for covered employees, whether or not those covered employees are San Francisco residents. Notwithstanding any other provision of this subsection, "health care expenditure" shall not include any payment made directly or indi-

rectly for workers' compensation or Medicare benefits.

(8) "Health care expenditure rate" means the amount of health care expenditure that a covered employer shall be required to make for each hour paid for each of its covered employees each quarter. The "health care expenditure rate" shall be computed as follows:

(a) From the effective date of this Chapter through June 30, 2007, $1.60 per hour for large businesses and $1.06 per hour for medium-sized businesses;

(b) From July 1, 2007 through December 31, 2007, January 1, 2008 through December 31, 2008, and January 1, 2009 through December 31, 2009, the rates for large and medium-sized businesses shall increase five (5) percent over the expenditure rate calculated for the preceding year;

(c) From January 1, 2010 and each year thereafter, the "health care expenditure rate" shall be determined annually based on the "average contribution" for a full-time employee to the City Health Service System pursuant to Section A8.423 of the San Francisco Charter based on the annual ten county survey amount for the applicable fiscal year, with such average contribution prorated on an hourly basis by dividing the monthly average contribution by one hundred seventy-two (172) (the number of hours worked in a month by a full-time employee). The "health care expenditure rate" shall be seventy-five percent (75%) of the annual ten county survey amount for the applicable fiscal year for large businesses and fifty percent (50%) for medium-sized businesses.

(9) "Health care services" means medical care, services, or goods that may qualify as tax deductible

medical care expenses under Section 213 of the Internal Revenue Code, or medical care, services, or goods having substantially the same purpose or effect as such deductible expenses.

(10) "Hour paid" or "hours paid" means a work hour or work hours for which a person is paid wages or is entitled to be paid wages for work performed within the City, including paid vacation hours and paid sick leave hours, but not exceeding 172 hours in a single month. For salaried persons, "hours paid" shall be calculated based on a 40-hour work week for a full-time employee.

(11) "Large business" means an employer for which an average of one hundred (100) or more persons per week perform work for compensation during a quarter.

(12) "Medium-sized business" means an employer for which an average of between twenty (20) and ninety-nine (99) persons per week perform work for compensation during a quarter.

(13) "Person" means any natural person, corporation, sole proprietorship, partnership, association, joint venture, limited liability company, or other legal entity.

(14) "Required health care expenditure" means the total health care expenditure that a covered employer is required to make every quarter for all its covered employees.

(15) "Small business" means an employer for which an average of fewer than twenty (20) persons per week perform work for compensation during a quarter.

(Added by Ord. 218-06, File No. 051919, App. 8/4/2006; Ord. 69-07, File No. 070255, App. 4/2/2007)

SEC. 14.2. SAN FRANCISCO HEALTH ACCESS PROGRAM AND REIMBURSEMENT ACCOUNTS.

(a) The San Francisco Department of Public Health shall administer the Health Access Program. Under the Health Access Program, uninsured San Francisco residents may obtain health care from a network consisting of San Francisco General Hospital and the Department of Public Health's clinics, and other community non-profit and private providers that meet the program's quality and other criteria for participation. The Health Access Program is not an insurance plan for Health Access Program participants.

(b) The Department of Public Health shall coordinate with a third party vendor to administer program operations, including basic customer services, enrollment, tracking service utilization, billing, and communication with the participants.

(c) The Health Access Program shall be open to uninsured San Francisco residents, regardless of employment status. Eligibility criteria shall be established by the Department of Public Health, but no person shall be excluded from the Health Access Program based on a pre-existing condition. Participants may enroll themselves as individuals, with the terms of enrollment to be determined pursuant to Section 14.4(a).

(d) The Health Access Program may be funded from a variety of sources, including payments from covered employers pursuant to Section 14.3, from individuals, and from the City. Funding from the City shall prioritize services for low and moderate income persons, with costs based on the Health Access Program participant's ability to pay.

(e) The Health Access Program shall use the "Medical Home" model in which a primary care physician, nurse practitioner, or physician assistant develop and direct a plan of care for each Health Access Program participant, coordinate referrals for testing and specialty services, and monitor management of chronic conditions and diseases. Health Access Program participants shall be assigned to a primary care physician, nurse practitioner, or physician assistant.

(f) The Health Access Program shall provide medical services with an emphasis on wellness, preventive care and innovative service delivery. The Program shall provide medical services for the prevention, diagnosis, and treatment of medical conditions, excluding vision, dental, infertility, and cosmetic services. The Department of Public Health may further define the services to be provided, except that such services must, at a minimum, include: professional medical services by doctors, nurse practitioners, physician assistants, and other licensed health care providers, including preventive, primary, diagnostic and specialty services; inpatient and outpatient hospital services, including acute inpatient mental health services; diagnostic and laboratory services, including therapeutic radiological services; prescription drugs, excluding drugs for excluded services; home health care; and emergency care provided in San Francisco by contracted providers, including emergency medical transportation if needed.

(g) The Department of Public Health shall also be authorized to use payments made to the City by employers to satisfy their expenditure requirements as set forth in Section 14.3 to establish and maintain reimbursement accounts from which covered em-

ployees may obtain reimbursement of health care expenditures.

(h) The City Controller shall ensure any required health care expenditures made by an employer to the City are kept separate and apart from general funds and shall limit use of the expenditures to the Health Access Program or to the establishment and maintenance of reimbursement accounts from which covered employees may obtain reimbursement of health care expenditures. If any covered employee fails to enroll in the Health Access Program or establish a reimbursement account with the Department of Public Health within a reasonable time, as determined by the Department of Public Health, the City may use the funds paid to the City and County of San Francisco on behalf of that employee for the benefit of the health care programs created by this Ordinance, but the City may not transfer these funds to the City's general fund.

(Added by Ord. 218-06, File No. 051919, App. 8/4/2006; Ord. 69-07, File No. 070255, App. 4/2/2007)

SEC. 14.3. REQUIRED HEALTH CARE EXPENDITURES.

(a) Required Expenditures. Covered employers shall make required health care expenditures to or on behalf of their covered employees each quarter. The required health care expenditure for a covered employer shall be calculated by multiplying the total number of hours paid for each of its covered employees during the quarter (including only hours starting on the first day of the calendar month following ninety (90) calendar days after a covered employee's date of hire) by the applicable health care expenditure rate. In determining whether a covered

employer has made its required health care expenditures, payments to or on behalf of a covered employee shall not be considered if they exceed the following amount: the number of hours paid for the covered employee during the quarter multiplied by the applicable health care expenditure rate. The City's Office of Labor Standards Enforcement (OLSE) shall enforce the health expenditure requirements under this Section.

(b) Additional Employer Responsibilities. A covered employer shall: (i) maintain accurate records of health care expenditures, required health care expenditures, and proof of such expenditures made each quarter each year, and allow OLSE reasonable access to such records, provided, however, that covered employers shall not be required to maintain such records in any particular form; and (ii) provide information to the OLSE, or the OLSE's designee, on an annual basis containing such other information as OLSE shall require, but OLSE may not require an employer to provide information in violation of State or federal privacy laws. Where an employer does not maintain or retain adequate records documenting the health expenditures made, or does not allow OLSE reasonable access to such records, it shall be presumed that the employer did not make the required health expenditures for the quarter for which records are lacking, absent clear and convincing evidence otherwise. The Office of Treasurer and Tax Collector shall have the authority to provide any and all nonfinancial information to OLSE necessary to fulfill the OLSE's responsibilities as the enforcing agency under this Ordinance. With regard to all such information provided by the Office of Treasurer and Tax Collector, OLSE shall be subject to the confidentiality provisions of Subsection (a) of Section

6.22-1 of the San Francisco Business and Tax Regulations Code.

(Added by Ord. 218-06, File No. 051919, App. 8/4/2006; Ord. 69-07, File No. 070255, App. 4/2/2007)

SEC. 14.4. ADMINISTRATION AND ENFORCEMENT.

(a) The City shall develop and promulgate rules to govern the operation of this Chapter. The regulations shall include specific rules by the Department of Public Health on the operation of both the Health Access Program and the reimbursement accounts identified in Section 14.2(g), including but not limited to eligibility for enrollment in the Health Access Program and establishment of reimbursement accounts and rules by the OLSE for enforcement of the obligations of the employers under this Chapter. The rules shall also establish procedures for covered employers to maintain accurate records of health care expenditures and required health care expenditures and provide a report to the City without requiring any disclosures of information that would violate State or Federal privacy laws. The rules shall further establish procedures for providing employers notice that they may have violated this Chapter, a right to respond to the notice, a procedure for notification of the final determination of a violation, and an appeal procedure before a hearing officer appointed by the City Controller. The sole means of review of the hearing officer's decision shall be by filing in the San Francisco Superior Court a petition for a writ of mandate under Section 1094.5 of the California Code of Civil Procedure. No rules shall be adopted finally until after a public hearing.

(b) During implementation of this Chapter and on an ongoing basis thereafter, the City shall maintain an education and advice program to assist employers with meeting the requirements of this Chapter.

(c) Any employer that reduces the number of employees below the number that would have resulted in the employer being considered a "covered employer," or below the number that would have resulted in the employer being considered a medium-sized or large business, shall demonstrate that such reduction was not done for the purpose of evading the obligations of this Chapter or shall be in violation of the Chapter.

(d) It shall be unlawful for any employer or covered employer to deprive or threaten to deprive any person of employment, take or threaten to take any reprisal or retaliatory action against any person, or directly or indirectly intimidate, threaten, coerce, command or influence or attempt to intimidate, threaten, coerce, command or influence any person because such person has cooperated or otherwise participated in an action to enforce, inquire about, or inform others about the requirements of this Chapter. Taking adverse action against a person within ninety (90) days of the person's exercise of rights protected under this Chapter shall raise a rebuttable presumption of having done so in retaliation for the exercise of such rights.

(e) (1) The City shall enforce the obligations of employers and covered employers under this Chapter, and may impose administrative penalties upon employers and covered employers who fail to make required health care expenditures on behalf of their employees. The amount of the penalty shall be up to one-and-one-half times the total expenditures that a covered employer failed to make plus simple annual

interest of up to ten (10) percent from the date payment should have been made, but in any event the total penalty for this violation shall not exceed $1,000.00 for each employee for each week that such expenditures are not made.

(2) For other violations of this Chapter by employers and covered employers, the administrative penalties shall be as follows: For refusing to allow access to records, pursuant to Section 14.3(b), $25.00 as to each worker whose records are in issue for each day that the violation occurs; for the failure to maintain or retain accurate and adequate records pursuant to Section 14.3(b) and for the failure to make the annual report of information required by OLSE pursuant to Section 14.3(b). $500.00; for violation of Section 14.4(d) (retaliation), $100.00 as to each person who is the target of the prohibited action for each day that the violation occurs; and for any other violation not specified in this subsection (e)(2), $25.00 per day for each day that the violation occurs.

(3) The City Attorney may bring a civil action to recover civil penalties for the violations set forth in subsections (e)(1) and (e)(2) in the same amounts set forth in those subsections, and to recover the City's enforcement costs, including attorneys' fees.

(4) Amounts recovered under this Section shall be deposited in the City's General Fund.

(f) The City Controller shall coordinate with the Department of Public Health and OLSE to prepare periodic reports on the implementation of this Chapter including participant rates, any effect on services provided by the Department of Public Health, the cost of providing services to the Health Access Program participants and the economic impact of the

Chapter's provisions. Reports shall be provided to the Board of Supervisors on a quarterly basis for quarters beginning July 1, 2007 through June 30, 2008, then every six months through June 30, 2010. Reports shall include specific information on any significant event affecting the implementation of this Chapter and also include recommendations for improvement where needed, in which case the Board of Supervisors or a committee thereof shall hold a hearing within thirty (30) days of receiving the report to consider responsive action.

(g) The Director of Public Health shall convene an advisory Health Access Working Group to provide the Department of Public Health and the Health Access Program with expert consultation and direction, with input on members from the Mayor and the Board of Supervisors. The Health Access Working Group shall be advisory in nature and may provide the Health Access Program with input on matters including: setting membership rates; designing the range of benefits and health care services for participants; and researching utilization, actuaries, and costs.

(h) The Department of Public Health and the OLSE shall report to the Board of Supervisors by July 1, 2007, on the development of rules for the Health Access Program and for the enforcement and administration of the employer obligations under this Chapter. The Board of Supervisors or a committee thereof shall hold a hearing on the proposed rules to ensure that participants in the Health Access Program shall have access to high quality and culturally competent services.

(Added by Ord. 218-06, File No. 051919, App. 8/4/2006; Ord. 69-07, File No. 070255, App. 4/2/2007)

SEC. 14.5. SEVERABILITY.

If any section, subsection, clause, phrase, or portion of this Chapter is for any reason held invalid or unconstitutional by any court or Federal or State agency of competent jurisdiction, such portion shall be deemed a separate, distinct and independent provision and such holding shall not affect the validity of the remaining portions thereof. To this end, the provisions of this ordinance shall be deemed severable.

(Added by Ord. 218-06, File No. 051919, App. 8/4/2006)

SEC. 14.6. PREEMPTION.

Nothing in this Chapter shall be interpreted or applied so as to create any power, duty or obligation in conflict with, or preempted by, any Federal or State law.

(Added by Ord. 218-06, File No. 051919, App. 8/4/2006)

SEC. 14.7. GENERAL WELFARE.

By this Chapter, the City is assuming an undertaking only to promote the general welfare and otherwise satisfy its obligations to provide health care under applicable law. This Chapter should in no way be construed as an expansion of the City's existing obligations to provide health care under State and Federal law, and the City shall set all necessary criteria for enrollment consistent with its legal obligations. The City is not assuming, nor is it imposing on its officers and employees, an obligation for breach of which it is liable in money damages to any person who claims that such breach proximately caused injury. To the fullest extent permitted by law, the City shall assume no liability whatsoever. To the fullest extent permitted by law, any actions taken by a public officer or employee under the provisions of

this Chapter shall not become a personal liability of any public officer or employee of the City.

(Added by Ord. 218-06, File No. 051919, App. 8/4/2006)

SEC. 14.8. OPERATIVE DATE.

This Chapter shall become operative in three phases. The day this Chapter becomes effective, implementation of the Chapter shall commence. The Health Access Program shall become operative on July 1, 2007. Any requirements on employers for which an average of fifty (50) or more persons per week perform work for compensation during a quarter shall become operative on January 1, 2008. Any requirements on employers for which an average of from twenty (20) to forty-nine (49) persons per week perform work for compensation during a quarter shall become operative on April 1, 2008. This Chapter is intended to have prospective effect only.

(Added by Ord. 218-06, File No. 051919, App. 8/4/2006; Ord. 72-07, File No. 070354, App. 4/2/2007)

APPENDIX G

CITY AND COUNTY OF SAN FRANCISCO
OFFICE OF LABOR STANDARDS ENFORCEMENT

Donna Levitt, Manager

REGULATIONS IMPLEMENTING THE EMPLOYER SPENDING REQUIREMENT OF THE SAN FRANCISCO HEALTH CARE SECURITY ORDINANCE (HCSO)

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OLSE Regulations Implementing the Employer Spending Requirement of the San Francisco health Security Ordinance (HCSO)

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For specific inquiries regarding the HCSO, please call (415) 554-7892 or email HCSO@sfgov.org.

INTRODUCTION

The Office of Labor Standards Enforcement ("OLSE") promulgates these Regulations pursuant to Chapter 2A, Article 1, Section 2A.23 and Chapter 14 of the San Francisco Administrative Code. Pursuant to Chapter 14, the San Francisco Health Care Security Ordinance ("HCSO"), the OLSE is mandated to enforce the Employer Spending Requirement of the HCSO.

From February 1 through July 17, 2006, and again on March 7 and May 8, 2007, the Board of Supervisors held 19 hearings at which there were opportunities for public comment on the HCSO and its amendments. In January and June of 2007, the OLSE issued draft Regulations, which were vetted through a public process that included public hearings and the opportunity to provide both oral and written comments and updated several times based upon public input.

In developing these Regulations, the OLSE has been guided by its understanding of the importance of fulfilling the goals of the Ordinance, providing clear direction to employers and employees, and giving weight to considerations of equity and practicality.

Fulfilling the goals of the Ordinance. In developing these Regulations, the OLSE has tried to be faithful to the basic goals of the Ordinance. These goals are well established. The Ordinance and its amendments include extensive statements of legislative findings and purpose, explaining the multiple rationales for the Ordinance and articulating its goals. These statements of legislative findings and purpose is found in Sections 1 of the Ordinance and Amended

Ordinance, and, as such, have the full force and effect of law. Particularly in light of the statements of legislative findings and purpose, the Ordinance should be liberally construed to effect its goals.

Providing clear direction to employers and employees. In mandating the OLSE to promulgate regulations on the Employer Spending Requirement of the Ordinance, the Board of Supervisors intended that the OLSE provide clear direction to employers and employees upon which they could rely. (See S.F. Admin. Code § 14.4(a).) Accordingly, these Regulations seek to fulfill that mandate.

Giving weight to considerations of equity and practicality. Finally, in adopting the Ordinance, the Board of Supervisors intended that guidelines or regulations take into account considerations of equity and practicality, from both the employee and employer perspective. Accordingly, these Regulations are designed to be both fair and workable for employees and employers alike. One aspect of the Regulations, though not a dominant feature, is to reduce the possibility of abuses by employees and employers.

While these principles have guided the OLSE's judgment in developing these Regulations, it must be acknowledged that general principles do not always automatically yield a single, specific result with respect to a particular Regulation. Multiple and sometimes conflicting considerations come into play in the development of a Regulation. Having been authorized by the Ordinance to promulgate these Regulations, the OLSE ultimately must exercise its judgment in developing Regulations that are reasonable in light of all relevant factors, taking into account both input from the public and its own expertise as a labor standards enforcement office.

REGULATION 1: EMPLOYER SPENDING REQUIREMENT

1.1 Employer Spending Requirement

(A) Each quarter, covered employers are required to make qualifying health care expenditures:

(1) to their covered employees, or

(2) for the benefit of their covered employees.

For the definition of qualifying health care expenditures, *see* Regulation 4.

1.2 Definition of Quarter

A quarter shall be defined as one of four three-month periods in a calendar year. Thus, the first quarter of the year shall be defined as the period from January 1 through March 31; the second quarter shall be the period from April 1 through June 30; the third quarter, the period from July 1 through September 30; and the fourth quarter, the period from October 1 through December 31.

For timing and manner of payment of the Employer Spending Requirement, *see* Regulation 6.2.

REGULATION 2: COVERED EMPLOYERS

2.1 Definition of Employer

An employer is an employing unit as defined in Section 135 of the California Unemployment Insurance Code or any person defined in Section 18 of the California Labor Code. An employer includes all members of a "controlled group of corporations" as defined in Section 1563(a) of the United States Internal Revenue Code, and the determination shall be made without regard to Sections 1563(a)(4) and 1563(e)(3)(C) of the Internal Revenue Code.

2.2 Covered Employer

(A) A "covered employer" is:

(1) any Medium-size or Large Business, as defined in subsection C below, that;

(2) engages in business within the City and is required to obtain a valid San Francisco business registration certificate pursuant to Article 12 of the Business and Tax Regulations Code.

(B) Whether an employer is physically located within the geographic boundaries of the City and County of San Francisco has no bearing on whether it meets the definition of a "covered employer." (In contrast, however, only persons who work for a covered employer within the geographic boundaries of the City and County of San Francisco may be considered "covered employees." *See* Regulation 3.)

(C) The law defines three categories of employers:

(1) Large Business: an employer for which an average of 100 or more persons per week perform work for compensation during a quarter. This category shall include nonprofit corporations for which an average of 100 or more persons per week perform work for compensation during a quarter.

(2) Medium-size Business: an employer for which an average of 20 to 99 persons per week perform work for compensation during a quarter. This category shall include only those nonprofit corporations for which an average of 50 to 99 persons per week perform work for compensation during a quarter.

(3) Small Business: an employer for which an average of 19 or fewer persons per week perform work for compensation during a quarter.

(D) For the purposes of determining employer size, the term "persons":

(1) shall include all employees, regardless of their status or classification as seasonal, permanent or temporary, full-time or part-time, contracted (whether employed directly by the employer or through a temporary staffing agency, leasing company, professional employer organization, or other entity) or commissioned;

(2) shall not be limited to covered employees, as defined in Regulation 3; and

(3) shall include both those who work within San Francisco and those who work outside of San Francisco.

(E) For businesses employing a fluctuating number of employees during a quarter, employer size will be determined based on the average number of persons per week performing work for compensation during the applicable quarter.

(F) Effective Dates of Coverage

(1) This law shall be effective on January 1, 2008 for all employers for which an average of 50 or more persons per week perform work for compensation during a quarter.

(2) This law shall become effective April 1, 2008 for all for-profit businesses for which an average of 20 or more persons per week perform work for compensation during a quarter.

(3) Non-profit Medium-size Businesses for which an average of 49 or fewer persons per week perform work for compensation during a quarter and all Small Businesses are exempt from the requirements of this Ordinance.

REGULATION 3: COVERED EMPLOYEES

3.1 Covered Employees

(A) A covered employee is any person who:

(1) qualifies as an employee entitled to payment of minimum wage pursuant to the Minimum Wage Ordinance, Chapter 12R of the San Francisco Administrative Code;

(2) has been employed by his or her employer for 90 calendar days after his or her first day of work (including any period of leave to which an employee is legally entitled); and,

(3) in a particular week performs at least the number of hours of work specified below:

(a) Beginning January 1, 2008: in a particular week performs at least 10 hours of work for the employer within the geographic boundaries of the City and County of San Francisco.

(b) Beginning January 1, 2009: in a particular week performs at least 8 hours of work for the employer within the geographic boundaries of the City and County of San Francisco.

(c) For employees whose work hours fluctuate from week to week, eligibility will be determined based on the average number of hours worked per week during the applicable quarter.

(B) 90-Calendar-Day Eligibility Period. The 90-calendar-day eligibility period need not be continuous, consecutive, nor completed in the same calendar year.

(1) For an employee who is separated from employment prior to completing the eligibility period, the prior days of employment shall count towards the

eligibility period if the employee returns to work within one (1) year of the most recent separation date.

(2) An employee who is separated from employment after completing the eligibility period shall not be required to complete a new eligibility period, if the employee is rehired within one (1) year of the most recent separation date.

(C) Work Performed "Within" the City and County of San Francisco

(1) While employees who travel through San Francisco in the performance of their job duties shall not be considered to have performed work in San Francisco, an employee whose work requires stops in San Francisco (for example, to make pick-ups or deliveries) shall be considered to have performed work in San Francisco. For these employees, hours worked shall include travel within the geographic boundaries of the City and County of San Francisco. *See* Regulation 6.1(C)(1)(c).

(2) Work performed on city-owned or city-leased property outside the geographic boundaries of the City and County of San Francisco shall not be considered in meeting the hours requirement in Regulation 3.1(A)(3).

(3) For employees who live in San Francisco, work performed for a covered employer from the employee's own home, including telecommuting, shall qualify as work performed "within" the City and County of San Francisco.

(D) An employee's status or classification as seasonal, permanent or temporary, full-time or part-time, exempt or non-exempt, salaried or hourly, or contracted (whether employed directly by the em-

ployer or through a temporary staffing agency, leasing company, professional employer organization, or other entity) or commissioned shall not be considered in determining whether that employee is a covered employee.

(E) Employees made available to work through the services of a temporary staffing agency, leasing agency, professional employer organization, or other entity serving the same or similar function may or may not be considered employees of such entity. Both the client and the temporary staffing, leasing, professional employer, or similar entity may be considered an employer under this Ordinance, and each party shall have an obligation to ensure that the Employer Spending Requirement is met.

(F) Whether an employee is simultaneously employed by more than one employer shall not impact a covered employer's responsibilities under this law.

3.2 Covered Employee Exemptions

(A) The following persons are not covered employees under the HCSO:

(1) Persons who are managerial, supervisory, or confidential employees, unless such employees earn under $74,558 annually (or $35.85 hourly) in 2007. For each year thereafter, this figure shall increase by an amount corresponding to the prior year's increase, if any, in the Consumer Price Index for urban wage earners and clerical workers for the San Francisco-Oakland-San Jose metropolitan statistical area in California. For purposes of this exemption category,

(a) "managerial employee" is defined as an employee who has authority to formulate, determine, or effectuate employer policies by expressing and mak-

ing operative the decisions of the employer and who has discretion in the performance of his/her job independent of the employer's established policies;

(b) "supervisory employee" is defined as an employee who has authority, in the interest of the employer, to hire, transfer, suspend, lay off, recall, promote, discharge, assign, reward, or discipline other employees, or the responsibility to direct them, or to adjust their grievances, or effectively to recommend any such action, if the exercise of this authority or responsibility is not of a merely routine or clerical nature, but requires the use of independent judgment;

(c) "confidential employee" is defined as an employee who acts in a confidential capacity to formulate, determine, and effectuate management policies with regard to labor relations, or regularly substitutes for employees having such duties.

(2) Persons who are eligible to receive benefits under Medicare (as distinguished from Medicaid/Medi-Cal) or TRICARE/CHAMPUS (the federal health care and health benefits program for active duty and retired members of the uniformed services, their families, and survivors);

(3) Persons who are "covered employees" as defined in Section 12Q.2.9 of the San Francisco Administrative Code (Health Care Accountability Ordinance), if the employer meets the requirements set forth in Section 12Q.3 of the San Francisco Administrative Code for those employees;

(4) Persons who are employed by a non-profit corporation for up to one year as trainees in a bona fide training program consistent with federal law, which training program enables the trainee to ad-

vance into a permanent position, provided that the trainee does not replace, displace, or lower the wage or benefits of any existing position or employee;

(5) Persons who provide verification that they are receiving health care services through another employer, either as an employee or by virtue of being the spouse, domestic partner, or child of another person - provided that the employer obtains from those persons a voluntary written waiver of the health care expenditure requirements of the HCSO as follows. The employer must make its required health care expenditures on behalf of the employee unless all of the following requirements are met:

(a) Employers must use the Employee Voluntary Waiver Form provided in Appendix A.

i. The form must be voluntarily completed by the employee without pressure or coercion from the employee's coworkers or the employer, including, supervisor(s), manager(s), or their agents.

ii. An employee waiver is valid for one year, at which point a new waiver must be signed.

iii. Employees reserve the right to revoke their voluntary waiver at any time; however, the revocation must be submitted in writing.

iv. Employers must provide the employee with a complete copy of the Voluntary Waiver Form.

v. An electronic copy of the Voluntary Waiver Form shall be acceptable, provided that the employee receive a hard copy of any form(s) signed by the employee and the employee is readily able to access copies of such forms.

(b) Employers must maintain in their records a Voluntary Waiver Form signed by each employee for

whom the employer seeks to claim an exemption from the requirements of the HCSO, including information regarding the type and source of coverage (e.g., health insurance provided through the employer of the employee's spouse), as specified on the Voluntary Waiver Form, updated annually.

REGULATION 4: HEALTH CARE EXPENDITURES

4.1 Definition of Health Care Expenditure

(A) A health care expenditure is any amount paid by a covered employer to its covered employees or to a third party on behalf of its covered employees for the purpose of providing health care services for covered employees or reimbursing the cost of such services for its covered employees.

(B) Health care services means medical care, services, or goods that may qualify as tax deductible medical care expenses under Section 213 of the Internal Revenue Code, or medical care, services, or goods having substantially the same purpose or effect as such deductible expenses. Qualifying medical expenses include dental treatments and fees paid to dentists for x-rays, fillings, braces, extractions, dentures, and the like; eyeglasses and contact lenses needed for medical reasons; and fees for eye examinations and eye surgery to treat defective vision.

4.2 Examples of Qualifying Health Care Expenditures

(A) Each covered employer has discretion as to the type of health care expenditure it chooses to make for its covered employees. Examples of health care expenditures include, but are not limited to:

(1) Payments to a third party to provide health care services for a covered employee, e.g., health insurance premiums;

(2) Expenditures made by self-insured and/or self-funded insurance programs;

(3) Contributions on behalf of a covered employee to a health benefit flexible spending account, a health savings account, a health reimbursement account, a medical spending account (as defined under sections 125, 223 of the federal Internal Revenue Code and Publication 969 of the Internal Revenue Service), or to any other account having substantially the same purpose or effect without regard to whether such contributions qualify for a tax deduction or are excludable from employee income;

(4) Reimbursement to a covered employee for expenses incurred in the purchase of health care services;

(5) Costs incurred in the direct delivery of health care services for a covered employee; and,

(6) Payments on behalf of a covered employee to the City of San Francisco:

(a) to fund membership in the Health Access Program/Healthy San Francisco; or

(b) to establish and maintain medical reimbursement accounts for covered employees.

(B) Health care expenditures shall not include any payment made directly or indirectly to obtain workers' compensation, State Disability Insurance, Social Security, Medicare, or any other coverage required by any other local, state, or federal law.

(1) Prevailing Wage/Public Works Contracts. Payment of the prevailing wage fringe benefit re-

quirement in cash (as part of the covered employee's paycheck or otherwise) shall not satisfy the Employer Spending Requirement of this Ordinance.

(C) Employer health care expenditures shall include administrative costs paid to a third party for the purpose of providing health care services for covered employees, but shall not include administrative costs incurred by the employer, but not paid to a third party. Such costs are properly considered a business expense of the employer.

(D) Health care expenditures made on behalf of a covered employee for the benefit of his or her domestic partner, spouse, family member, or other dependent shall be included in determining whether an employer has met its required expenditure to or on behalf of the covered employee.

4.3 Other Qualifying Health Care Expenditures

Qualifying health care expenditures shall not be limited to those that qualify as tax deductible medical care expenses under Section 213 of the Internal Revenue Code and Publication 502 of the Internal Revenue Service, but may include medical care, services, or goods having substantially the same purpose or effect. Examples of qualifying expenditures include vision and dental coverage; nonprescription drugs, including, but not limited to, antacids, allergy medicines, pain relievers, and cold medicines; doctor's fees; and necessary hospital services not paid for by insurance.

REGULATION 5: HEALTH CARE EXPENDITURE RATES

5.1 Definition of Health Care Expenditure Rate

The health care expenditure rate is the amount of health care expenditure that a covered employer is

required to make for each hour paid for each of its covered employees during a quarter.

5.2 Health Care Expenditure Rates

(A) The health care expenditure rate for a covered employer is determined by that employer's size:

(1) Large Business. Beginning January 1, 2008, Large Businesses for which an average of 100 or more persons per week perform work for compensation during a quarter are required to make a health care expenditure of $1.76 per hour for each hour paid for each of its covered employees.

(2) Medium-Size Business

(a) Beginning January 1, 2008, Medium-size Businesses for which an average of 50-99 persons per week perform work for compensation during a quarter are required to make a health care expenditure of $1.17 per hour for each hour paid for each of its covered employees.

(b) Beginning April 1, 2008, all Medium-size Businesses (including those for which an average of 20-49 persons per week perform work for compensation during a quarter), except nonprofit corporations exempt from the definition of a covered employer, are required to make a health care expenditure of $1.17 per hour for each hour paid for each of its covered employees.

(B) Increases to Health Care Expenditure Rates

(1) For all covered businesses, the health care expenditure rate will be increased by 5% on January 1, 2009. Through 2009, the employer health care expenditure rate is as follows:

(2) From January 1, 2010 and each year thereafter, the "health care expenditure rate" shall be de-

termined annually based on the "average contribution" for a full-time employee to the City Health Service System pursuant to Section A8.423 of the San Francisco Charter based on the annual ten-county survey amount for the applicable fiscal year, with such average contribution prorated on an hourly basis by dividing the monthly average contribution by one hundred seventy-two (172) (the number of hours worked in a month by a full-time employee). The "health care expenditure rate" shall be seventy-five percent (75%) of the annual ten-county survey amount for the applicable fiscal year for large businesses and fifty percent (50%) for medium-sized businesses. Beginning in 2009 and in each year thereafter, the OLSE shall publish, by March 1, the adjusted expenditure rates for the upcoming calendar year

REGULATION 6: CALCULATING & MAKING HEALTH CARE EXPENDITURES

6.1 Calculating Health Care Expenditures

(A) A covered employer's required health care expenditure is the sum of the health care expenditure that the covered employer is required to make each quarter for each of its covered employees.

(B) The required health care expenditure is calculated by multiplying the total number of "hours paid," as defined below, to each covered employee during the quarter (starting on the first day of the calendar month following 90 calendar days after a covered employee's first day of work) by the applicable health care expenditure rate specified in Regulation 5.2.

(C) The required health care expenditures are based on hours paid, which may or may not be hours actually worked. "Hours paid" includes both hours

for which a person is paid wages for work performed within San Francisco and hours for which a person is entitled to be paid wages, including, but not limited to, paid vacation hours, paid time off, and paid sick leave hours, but not exceeding 172 hours in a single month or 516 hours in a single quarter.

(1) Work Performed and "Hours Paid" within San Francisco

(a) Any work performed by covered employees within San Francisco must be tracked by the employer. Unless there is clear and convincing evidence otherwise, all hours worked by covered employees will be presumed to be for work performed within San Francisco.

(b) For covered employees who perform some work outside of San Francisco, "hours paid" that are not hours actually worked (e.g., paid vacation hours, paid time off, and paid sick leave hours) will be calculated on a pro rata basis.

(c) Employees whose work requires stops in San Francisco (for example, to make pick-ups or deliveries) shall be considered to be performing work in San Francisco, and their "hours worked" shall include travel within the City and County of San Francisco.

(d) For covered employees who live in San Francisco and perform work for a covered employer from the employee's own home, including telecommuting, "hours worked" shall include all hours worked from home.

6.2 Timing and Manner of Health Care Expenditures

(A) The required health care expenditure must be made regularly, and no later than 30 days after the end of the preceding quarter.

(1) Employers meeting the requirements of the limited exception outlined in Regulation 6.2(B)(2) shall not be required to make expenditures under such plans quarterly.

(2) Nothing in this regulation shall prevent an employer from making regular expenditures prospectively, or before the end of a quarter, in order to obtain health care or health coverage for a covered employee during such quarterly period.

(B) Subject to the following limited exceptions, covered employers must make health care expenditures to or on behalf of each covered employee. Ordinarily, payments to or on behalf of one covered employee that exceed the required health expenditure for that employee will not be included in determining whether an employer has met its total required health care expenditures for all employees. However:

(1) A covered employer that provides uniform health coverage to some or all of its covered employees shall, with respect to those employees, be deemed to comply with the spending requirement of this Ordinance if the average expenditure rate per employee meets or exceeds the applicable expenditure rate (outlined in Regulation 5) for that employer.

(2) A covered employer that provides health coverage to some or all of its covered employees through a self-funded/self-insured plan shall, with respect to those employees, be deemed to comply with the spending requirement of this Ordinance if the preceding year's average expenditure rate per employee meets or exceeds the applicable expenditure rate (outlined in Regulation 5) for that employer.

(3) The average expenditure rate shall be calculated by dividing the total amount of health care ex-

penditures made for such employees by the total number of hours paid to such employees.

(C) An employer may choose more than one option to satisfy its duty to make the required health care expenditures for one or more of its covered employees. An employer may, for example, choose to purchase health insurance for its full-time employees, but make payment to the City to fund part-time employees' membership in the Health Access Program/Healthy San Francisco.

(D) The required health care expenditure must be made in full each quarter. Thus, an employer who purchases a health insurance program with premiums that are less than the required expenditure must choose a second option to make the expenditure in full. For example, the employer may choose to pay the remainder to the City to establish and maintain medical reimbursement accounts for such employees.

(E) A covered employer that maintains a health care program that requires contributions by a covered employee shall not have satisfied its obligation to make the required health care expenditures merely by offering a covered employee the opportunity to participate in such a program. Should the employee decline to participate in such a program, the employer shall not have satisfied its obligation to make the required health care expenditures.

REGULATION 7: ADDITIONAL EMPLOYER RESPONSIBILITIES

7.1 Employer Notice to Employee of Payment to the City

A covered employer who satisfies its obligation to make the required health care expenditures by making payment to the City shall provide its covered

employees with notice, using the form provided in Appendix B.

7.2 Employer Recordkeeping

(A) Covered employers shall keep, or cause to be kept, for a period of four years from the covered employees' dates of employment:

(1) itemized pay statements, as mandated by California Labor Code Section 226, which requires the following: (a) gross wages earned, (b) total hours worked by the employee (unless salaried), (c) the number of piece-rate units earned and any applicable piece rate if the employee is paid on a piece-rate basis, (d) all deductions, aggregated, (e) net wages earned, (f) the inclusive dates of the period for which the employee is paid, (g) the name of the employee and his or her social security number/the last four digits of his or her social security number or an employee identification number other than a social security number may be shown on the itemized statement, (h) the name and address of the legal entity that is the employer, and (i) all applicable hourly rates in effect during the pay period and the corresponding number of hours worked at each hourly rate by the employee;

(2) the employee's address, telephone number, date of first day of work;

(3) records sufficient to establish compliance with the Employer Spending Requirements of this Ordinance, including, as applicable, records of health care expenditures made, calculations of health care expenditures required under this Ordinance for each covered employee, and proof documenting that such expenditures were made at least quarterly each year; and, if applicable,

(4) a signed Employee Voluntary Waiver Form (see Appendix A) for every employee for whom a covered employer seeks to claim an exemption from the Employer Spending Requirement; and

(5) a copy of the Employer Notice to Employee of Payment to the City (see Appendix B).

(B) Employers meeting the requirements of the limited exception outlined in Regulation 6.2(8)(2) shall not be required to demonstrate that expenditures under such plans were made quarterly.

(C) All records necessary to establish compliance with the Employer Spending Requirements of this Ordinance shall be made accessible by covered employers to the OLSE.

(D) Where an employer does not maintain or retain adequate records documenting the health care expenditures made, or does not allow the OLSE reasonable access to such records, it shall be presumed that the employer did not make the required health care expenditures for the quarter for which records are lacking. This presumption shall be rebutted only by clear and convincing evidence.

7.3 Employer Reporting

Covered employers shall provide information to the City regarding its health care expenditures on an annual basis. Such information shall be provided on the HCSO Mandatory Annual Reporting Form, which shall be mailed to all registered businesses and returned with the employer's annual business registration submission to the City, as mandated by Article 12 of the Business and Tax Regulations Code. Additional copies of the HCSO Mandatory Annual Reporting Form may be obtained from the OLSE.

7.4 Employer Cooperation with OLSE Investigation & Enforcement

All covered employers shall cooperate fully with the OLSE in connection with any investigation of an alleged violation of this Ordinance or with any audit or inspection conducted by the OLSE.

7.5 Prohibition against Actions or Attempts to Avoid Employer Coverage

(A) It is unlawful for any employer to reduce the number of employees in order to:

(1) avoid being considered a covered employer, or to

(2) be subject to a lower health care expenditure rate.

(B) In the event of an investigation on a claim based on Section 14.4(c) of the Ordinance, the employer shall be required to demonstrate that such reduction in staffing was for a valid business reason.

7.6 Prohibition against Retaliation

(A) It shall be unlawful for any employer to deprive or threaten to deprive any person of employment, take or threaten to take any reprisal or retaliatory action against any person, or directly or indirectly intimidate, threaten, coerce, command or influence or attempt to intimidate, threaten, coerce, command or influence any person because such person has cooperated or otherwise participated in an action to enforce, inquire about, or inform others about the requirements of this Ordinance.

(B) Taking adverse action against a person within ninety (90) days of the person's exercise of rights protected under this Ordinance shall raise a rebuttable

presumption of having done so in retaliation for the exercise of such rights.

7.7 Prohibition against Discrimination

It shall be unlawful for any employer to refuse to hire, employ, or select for a training program leading to employment; to discharge from employment or from a training program leading to employment; or to discriminate against a person in compensation or in terms, conditions, or privileges of employment, based on whether s/he possesses health insurance coverage.

REGULATION 8: OLSE ENFORCEMENT

8.1 OLSE Investigation & Enforcement

(A) The OLSE has the authority to conduct investigation and monitoring and to seek, for violations of this Ordinance, all of the penalties imposed by this Ordinance in order to further its purposes. The Labor Standards Enforcement Officer and other City employees and agents or designees authorized to assist in the administration and enforcement of the requirements of this Ordinance shall have the right to engage in random inspections of employment sites; to have access to workers and other witnesses; and to conduct audits of employer records as reasonably deemed necessary to determine compliance with this Ordinance, including, but not limited to, employee time sheets, payroll records, employee paychecks, and other documents described in Regulation 7.2.

(B) Where prompt compliance is not forthcoming, the OLSE may take any appropriate enforcement action to secure compliance, including initiating a civil action, and/or, except where prohibited by state or federal law, requesting that City agencies or departments revoke or suspend any registration certificates, permits, or licenses held or requested by the em-

ployer or person until such time as the violation is remedied.

8.2 Administrative Complaint Procedure

(A) The OLSE shall have sole authority over the administration of the following complaint procedure. This procedure shall include, but need not be limited to, the following:

(1) Any person may file a complaint alleging one or more violations of this Ordinance;

(2) Before beginning to investigate the complaint, the Labor Standards Enforcement Officer shall determine if the allegations of the complaint are sufficient and, based on that assessment, shall determine either to dismiss it or to proceed with an investigation;

(3) If the Labor Standards Enforcement Officer determines at any time that the allegations contained in the complaint are without merit, the Labor Standards Enforcement Officer shall notify the complainant; and

(4) If the Labor Standards Enforcement Officer finds that any allegations in the complaint have merit, the Labor Standards Enforcement Officer shall investigate the matter.

(B) This complaint procedure shall not preclude the Labor Standards Enforcement Officer from initiating or proceeding with an investigation on his or her own authority.

8.3 Notice of Violation

(A) If the OLSE determines that an employer may have violated or is not in compliance with this Ordinance, the OLSE shall issue written notification to the

employer mandating compliance within no fewer than ten (10) calendar days from the date of the notification.

(B) The OLSE may, at its discretion, allow the employer additional time beyond the ten (10) calendar days to make the corrections should the OLSE determine that the employer is making a good faith effort to comply.

(C) If, after ten (10) days of the Notice of Violation to the employer by the OLSE, the violation or failure to comply continues and no resolution is imminent, the OLSE may issue a Determination of Violation.

8.4 Determination of Violation

(A) The Determination of Violation shall include:

(1) a description of the violation;

(2) a citation of the provisions of the law violated;

(3) a description of the corrective action required and a timeline within which the action(s) must be completed;

(4) the amount of administrative penalty imposed for the violation(s) and a timeline for payment of such penalty, if applicable;

(5) a description of the process for appealing the Determination of Violation, including the deadline for filing such an appeal; and

(6) the name and signature of the Director of the OLSE or his/her designee.

8.5 Service

(A) Service of a Notice of Violation or Determination of Violation may be accomplished as follows:

(1) The OLSE may obtain the signature of the employer or a representative of the employer responsible for the violation to establish personal service of the document; or

(2) The OLSE may post the document by affixing the document to a surface in a conspicuous place on the employer's place of business or the fixed location within the City from or at which the employer conducts business in the City; or

(3) The OLSE may serve the document by first class mail as follows:

(a) The document shall be mailed to the employer by first class mail, postage prepaid, with a declaration of service under penalty of perjury; and

(b) A declaration of service shall be made by the person mailing the document, show the date and manner of service by mail, and recite the name and address of the employer to whom the Notice of Violation or Determination of Violation is issued.

Service of the document by mail in the manner described above shall be effective on the date of the mailing.

REGULATION 9: CORRECTIVE ACTION AND ADMINISTRATIVE PENALTIES

9.1 Corrective Action

The OLSE may order employers who violate this Ordinance to take appropriate corrective action to address violations of this Ordinance. The OLSE shall not be limited to ordering the actions described below, but may order any other actions it deems necessary to correct the violation(s) committed. Where the OLSE has reason to believe that a violation has occurred, it may order any appropriate temporary or

interim relief to mitigate the violation or maintain the status quo, pending completion of a full investigation or hearing.

9.2 Administrative Penalties

(A) If corrective action is not taken, the OLSE may impose administrative penalties upon employers who violate this Ordinance, including, but not limited to, the violations described below. All penalties may be assessed by means of a Determination of Violation issued by the Director of the OLSE or his/her designee.

VIOLATION	CORRECTIVE ACTION	ADMINISTRATIVE PENALTY
Failure to make the required health care expenditures (Admin. Code §§ 14.3(a) & 14.4(c)):	The party shall be ordered to make the required health care expenditure on behalf of each employee or person whose rights under this Ordinance was violated, and/or to reimburse the individual for any and all out-of-pocket medical expenses incurred by that individual for the period during which the employer was in violation of this Ordinance, up to	The penalty assessed shall be up to one-and one-half times the total expenditures that a covered employer failed to make, plus interest of up to ten (10) percent on all due and unpaid health care expenditures, from the date payment should have been made. The total penalty for this violation shall not exceed $1,000 for each employee for each week that such expenditures were or are not made.

	the amount of the required health care expenditure. This payment shall be made retroactively, from the date the expenditure was due, and continuing until the case is resolved to the satisfaction of the OLSE.	
Failure to cooperate with the OLSE or otherwise impeding the OLSE's ability to conduct an audit or investigation (Admin. Code §§ 14.3(b) & 14.4(e)):	The party shall be ordered to cooperate with the OLSE, effective immediately.	The penalty assessed shall be $25 per day for each day that the violation occurred or occurs.
Failure to allow reasonable access to records of health care expenditures (Admin. Code §§ 14.3(b) & 14.4(e)):	The party shall be ordered to provide the OLSE with reasonable access to records of health care expenditures.	The penalty assessed shall be $25 for each worker whose records are at issue for each day that the violation occurred or occurs.

Failure to maintain or retain accurate and complete records, including destruction of relevant evidence (Admin. Code §§ 14.3 (b) & 14.4(e); Regulation 7.2):	The party shall be ordered to produce the records and documents outlined in Regulation 7.2 and to cooperate with the OLSE in reconstructing the records it should have maintained	The penalty assessed shall be $500.
Failure to satisfy the annual reporting requirement (Admin. Code §§ 14.3(b) and 14.4(e)):	The party shall be ordered to satisfy its annual reporting requirement.	The penalty assessed shall be $500
Reduction of the number of employees in order to (1) avoid being considered a covered employer, or to (2) be subject to a lower health care expenditure rate (Admin. Code §§ 14.4(c); Regulation 7.5):	The party shall demonstrate that such reduction was not done for the purpose of evading the obligations of this Ordinance, but for a valid business reason, or shall be in violation of this Ordinance. If unable to do so, the party shall be ordered to make the required	The penalty assessed shall be $25 per day for each day that the violation occurred or occurs.

	health care expenditure on behalf of each employee or person whose rights under this Ordinance was violated, and/or to reimburse the individual for any and all out-of-pocket medical expenses incurred by that individual for the period during which the employer was in violation of this Ordinance, up to the amount of the required health care expenditure. This payment shall be made retroactively, from the date the expenditure was due, and continuing until the case is resolved to the satisfaction of the OLSE.	

Retaliation, including harassment, and/or discrimination in violation of the Ordinance (Admin. Code §§ 14.4(d); Regulations 7.6-7.7):	The party shall be ordered to cease, or cause to cease, any and all retaliatory and/or discriminatory actions, and if applicable, to reinstate or otherwise compensate an employee whose rights under this Ordinance.	The penalty assessed shall be $100 for each worker or person whose rights under this Ordinance was violated for each day that the violation occurred or occurs.

(B) Payment of the penalty shall not excuse the failure to correct the violation, nor shall it bar any further enforcement action by the OLSE.

(C) If penalties and/or costs are the subject of administrative appeal or judicial review, then the accrual of such penalties and/or costs shall be stayed until the determination of such appeal or review is final.

9.3 Payment of Penalties and Interest

(A) All administrative penalties shall be made payable to the City and County of San Francisco, be due within thirty (30) days from the date of the Determination of Violation, and be deposited in the City's General Fund when collected.

(B) All interest owing on unpaid health care expenditures shall be made payable to the employee on whose behalf the expenditures should have been made and be due within thirty (30) days from the date of the Determination of Violation.

9.4 Collection of Penalties; Civil Enforcement

(A) The failure of any employer to pay a penalty assessed by Determination of Violation within the time specified on the Determination of Violation constitutes a debt to the City.

(B) The City Attorney may bring a civil action or pursue any other legal remedy to recover civil penalties for the violations set forth in subsections 14.4 (e)(1842) of this Ordinance in the same amounts set forth in those subsections, and to recover the City's enforcements costs, including attorneys' fees. Enforcement costs shall not count toward any maximum penalty amount set forth in these regulations.

(C) The City may create and impose liens against any property owned or operated by an employer who fails to pay a penalty assessed by the Determination of Violation. The procedures provided for in Article XX of Chapter 10 of the San Francisco Administrative Code shall govern the imposition and collection of such liens.

REGULATION 10: ADMINISTRATIVE APPEALS

10.1 Administrative Appeals

(A) Persons receiving a Determination of Violation may appeal it within fifteen (15) days from the date the document is served. The appeal must:

(1) be in writing and specify the basis for the appeal in detail,

(2) indicate a return address,

(3) be accompanied by the penalty amount,

(4) be filed with the Controller's Office, and

(5) be filed with a copy to the OLSE.

The failure of any person to file an appeal in accordance with the provisions of this Section shall constitute concession to the assessment, and the Determination of Violation shall be deemed final upon expiration of the 15-day period.

(B) Within fifteen (15) days of receiving a proper request for appeal, the Controller or his or her designee shall appoint a hearing officer (who shall not be employed in the Office of Labor Standards Enforcement) to hear and decide the administrative appeal and shall so advise the OLSE and the appellant.

(C) The hearing officer shall promptly set a date, time and place for a hearing on the appeal. Written notice of the time and place for the hearing may be served by first class mail.

(1) Service of the notice must be made at least ten (10) days prior to the date of the hearing to the appellant.

(2) The failure of any person to appear at the hearing shall constitute concession to the assessment,

(3) Except as otherwise provided by law, the failure to receive a properly addressed notice of the hearing shall not affect the validity of any proceedings under this Ordinance.

(D) The hearing must commence no later than thirty (30) days after service of notice of the hearing and conclude within seventy-five (75) days of such notification, unless that time is extended by mutual agreement of all parties.

(E) No later than five (5) days prior to the hearing, the appellant and the OLSE shall submit to the hearing officer, with simultaneous service on the op-

posing party, written information including, but not limited to, the following: the statement of issues to be determined by the hearing officer and a statement of the evidence to be offered and the witnesses to be presented at the hearing.

(F) The hearing officer appointed by the Controller or the Controller's designee shall conduct all appeal hearings under this Ordinance. The hearing officer may accept evidence on which persons would commonly rely in the conduct of their serious business affairs, including, but not limited to, the following:

(1) A valid Determination of Violation shall be prima facie evidence of the violation;

(2) The hearing officer may accept testimony relating to the violation and/or to the appropriate means of correcting the violation by declaration under penalty of perjury;

(3) The person responsible for the violation, or any other interested person, may present testimony or other evidence concerning the violation and the means and time frame for correction.

10.2 Burden of Proof

The appellant shall have the burden of proving that the basis for the Determination of Violation is incorrect.

10.3 Hearing

(A) Hearing Record. The hearing shall be open to the public and shall be tape-recorded. Any party to the hearing may, at his or her own expense, cause the hearing to be recorded and transcribed by a certified court reporter. The hearing officer may continue the hearing and request additional information from either party prior to issuing a written decision.

(B) Findings and Decision. The hearing officer shall make findings based on the record of the hearing and issue a written decision based on such findings within fifteen (15) days of conclusion of the hearing. The hearing officer's decision may:

(1) uphold the issuance of a Determination of Violation and penalties stated therein,

(2) dismiss a Determination of Violation, or

(3) uphold the issuance of the Determination of Violation but reduce, waive or conditionally reduce or waive the penalties stated in a Determination of Violation or any late fees assessed if mitigating circumstances are shown and the hearing of officer finds specific grounds for reduction or waiver in the evidence presented at the hearing.

The hearing officer may impose conditions and deadlines for the correction of violations or the payment of outstanding civil penalties.

(C) Finality of Hearing Officer's Decision. The decision of the hearing officer shall be final. If the hearing officer concludes that the violation(s) charged did not occur or that the person charged in the Determination of Violation was not the responsible party, the OLSE shall refund or cause to be refunded the penalty amount to the party that deposited such amount. The hearing officer's decision shall be served on the appellant and the OLSE by certified mail.

(D) Writ of Mandate. The sole means of review of the hearing officer's decision shall be made by filing in the San Francisco Superior Court a petition for a writ of mandate under Section 1094.5 of the California Code of Civil Procedure.